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(54) **MINIMALLY INVASIVE INSTRUMENT SET,
DEVICES AND RELATED METHODS**

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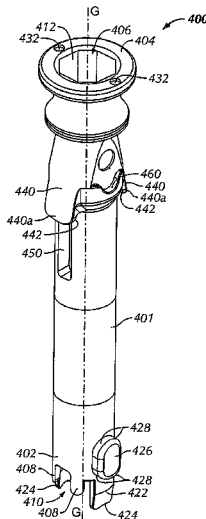
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(57) **ABSTRACT**

Methods of applying a locking cap to a bone anchor assembly.
The bone anchor assembly includes a bone anchor and an
elongate rod. The bone anchor includes a body that defines a
channel and has a tissue retractor coupled thereto that defines
a partial pathway to the channel.

25 Claims, 24 Drawing Sheets



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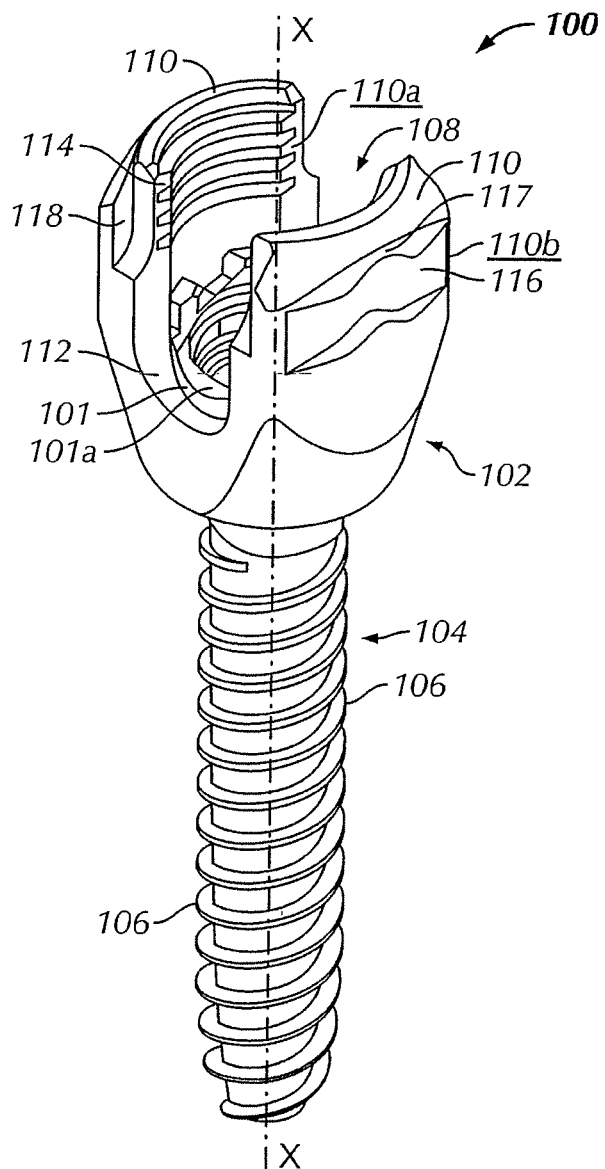


FIG. 1

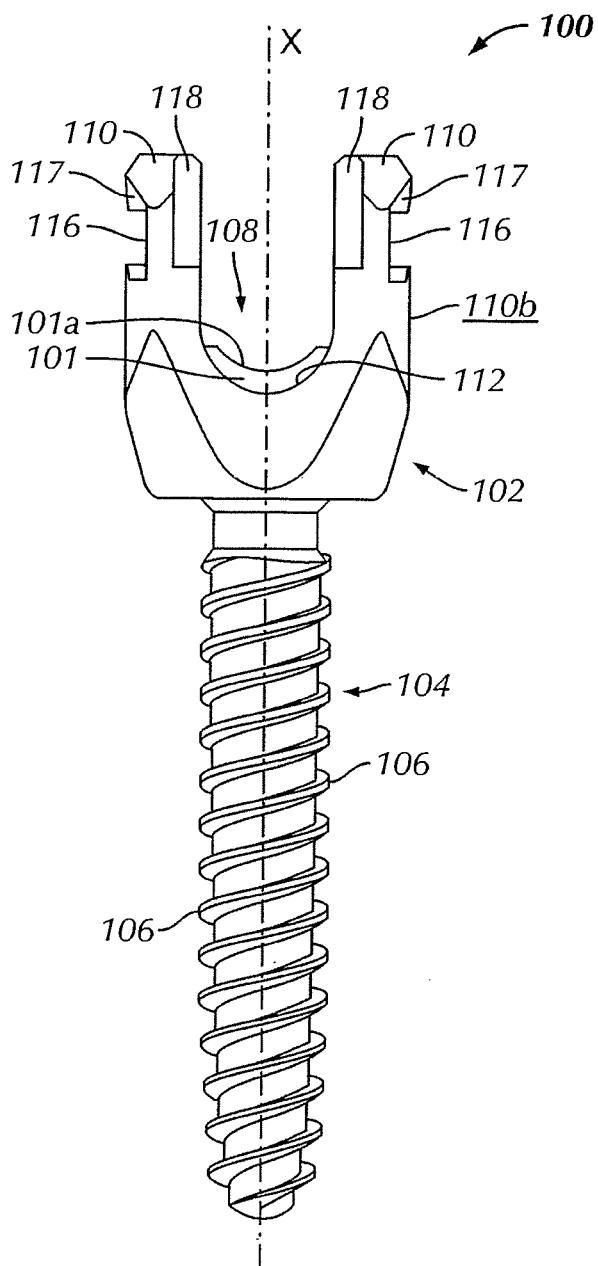


FIG. 2



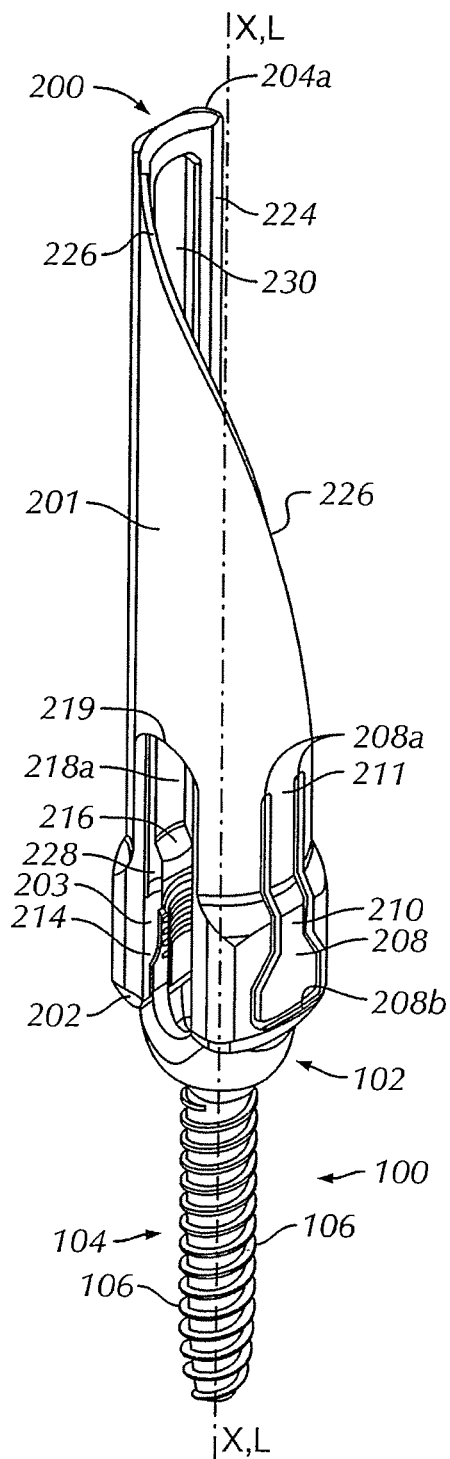


FIG. 5

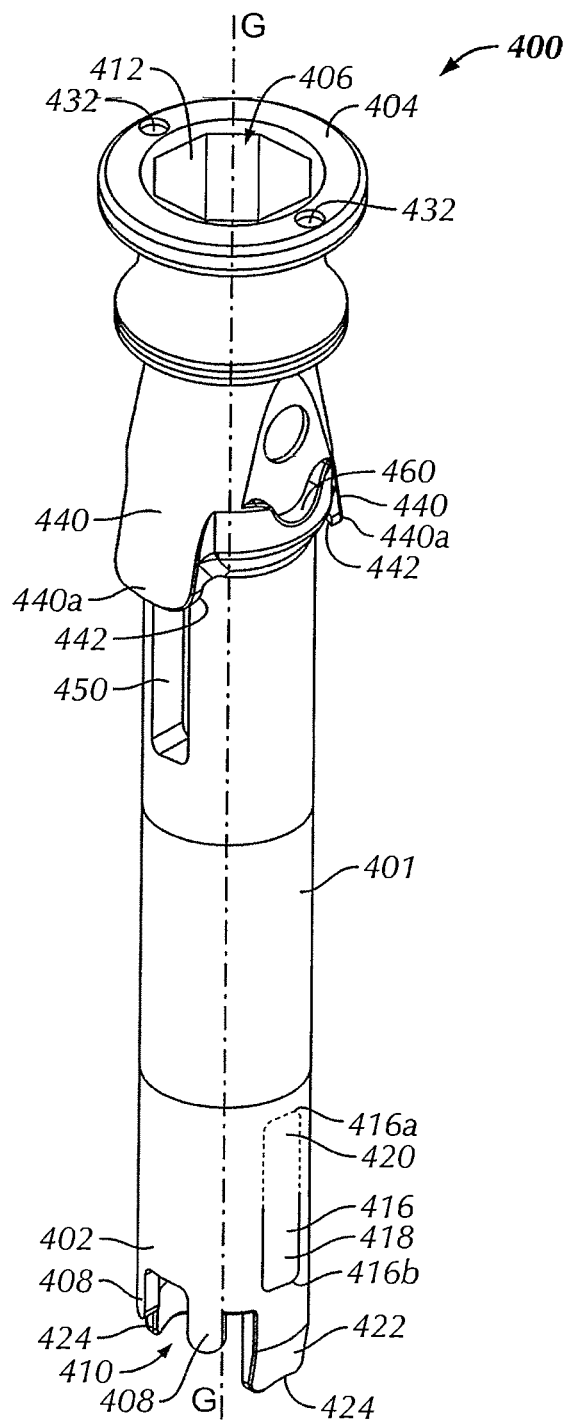


FIG. 6A

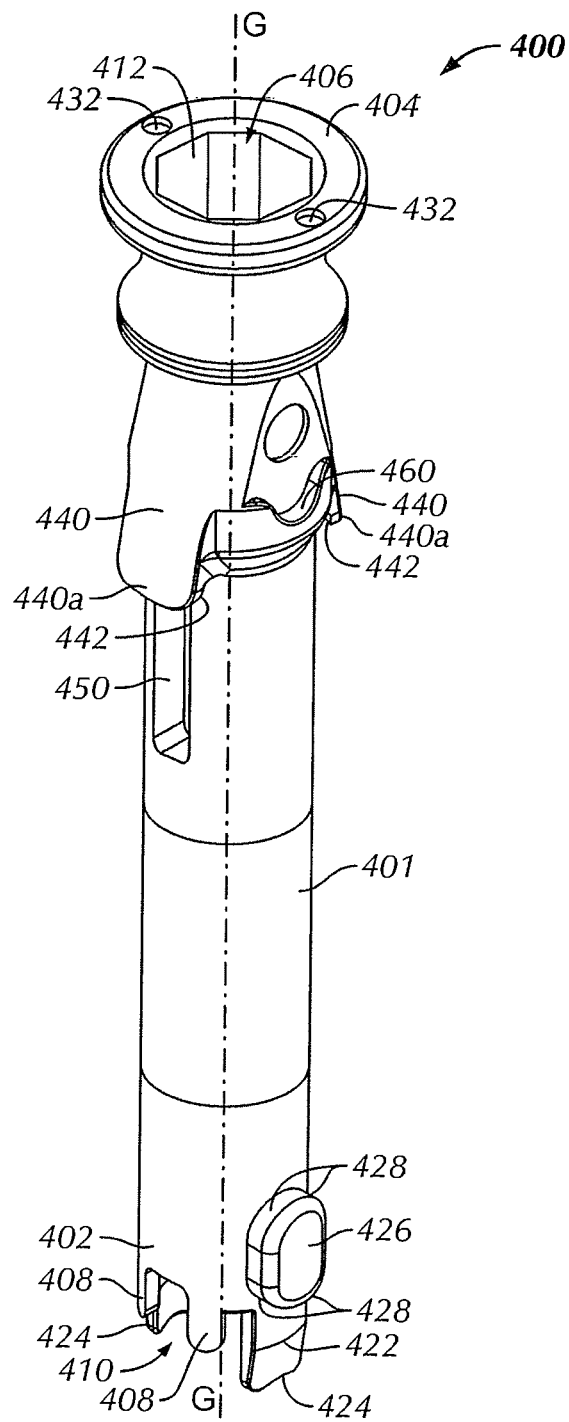
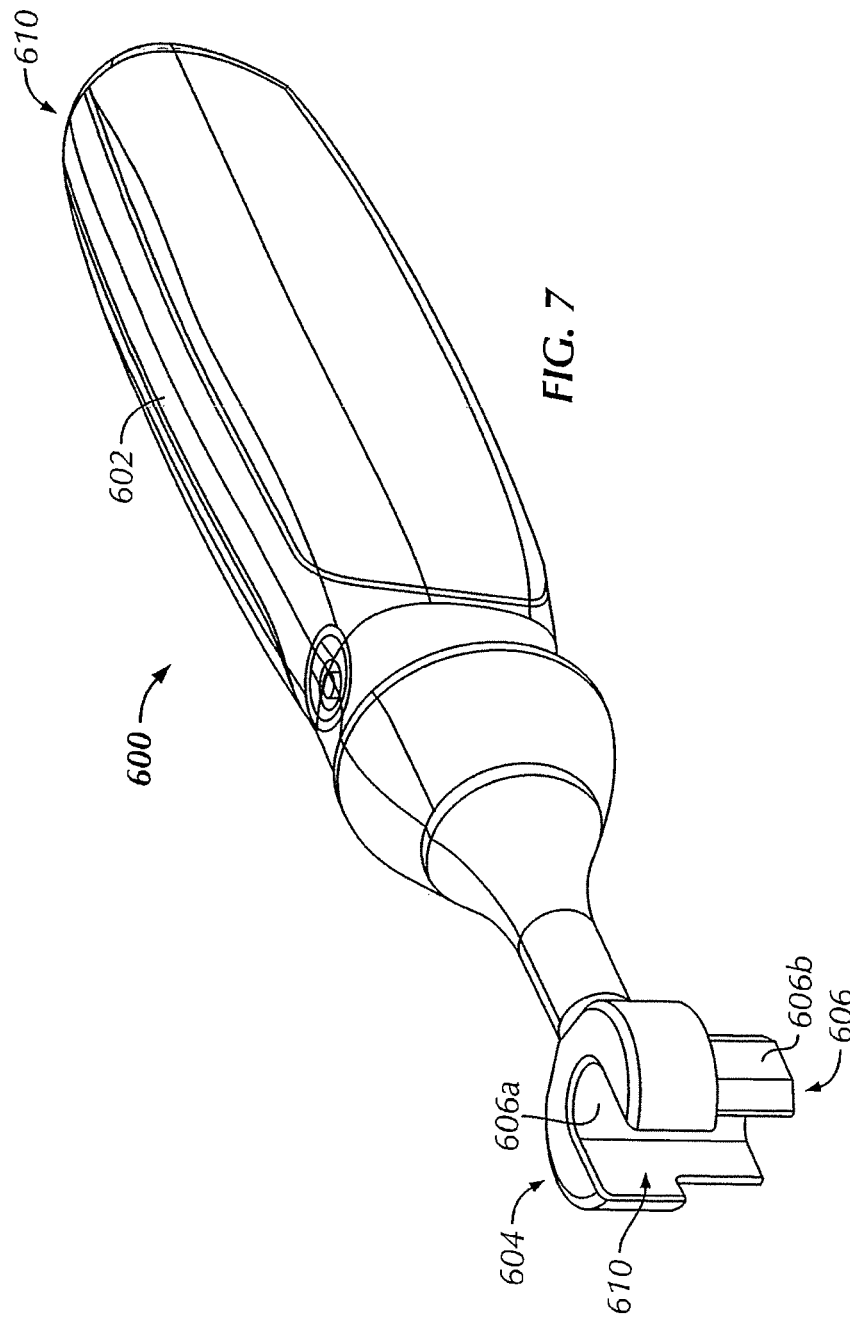


FIG. 6B



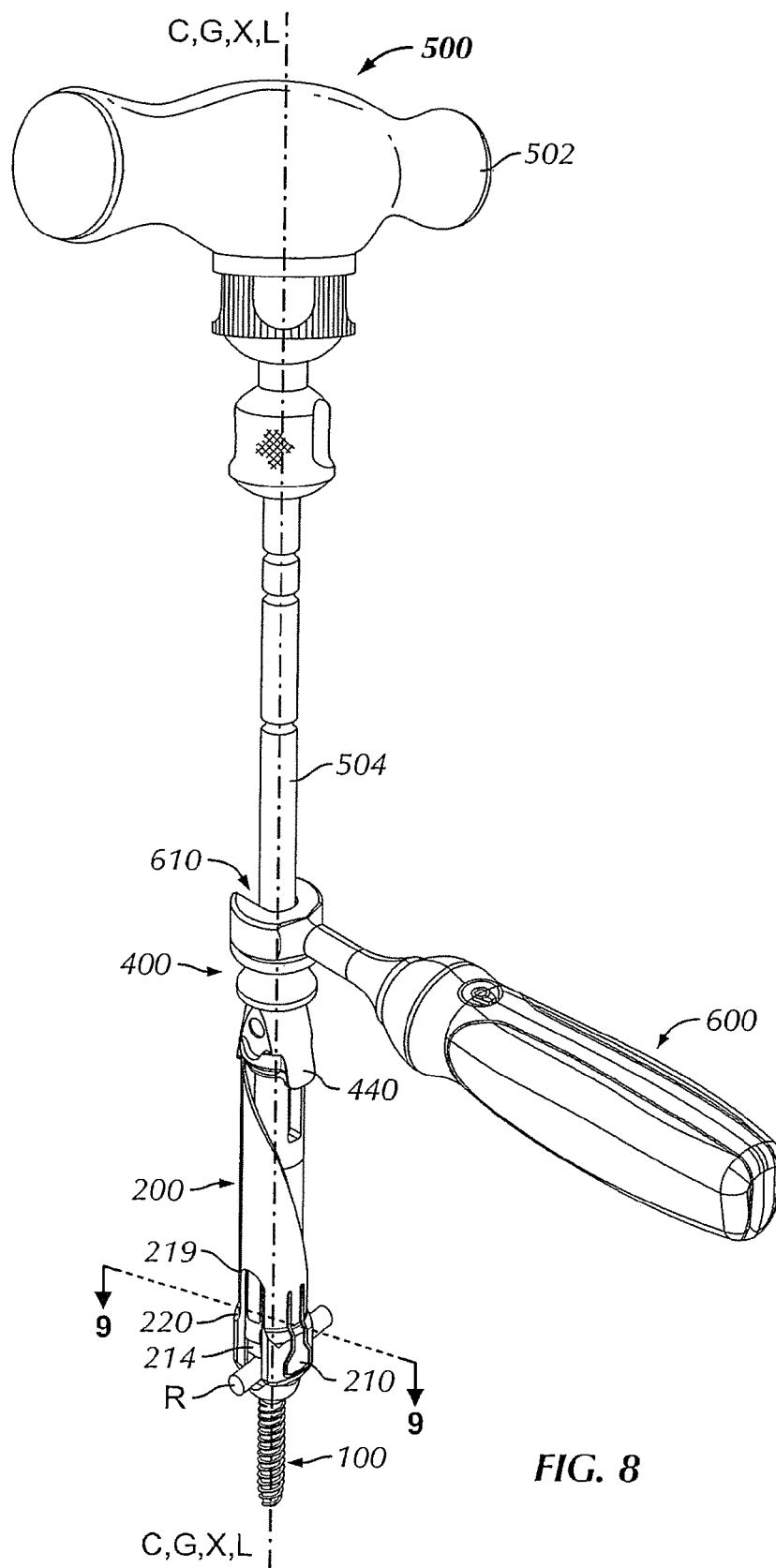


FIG. 8

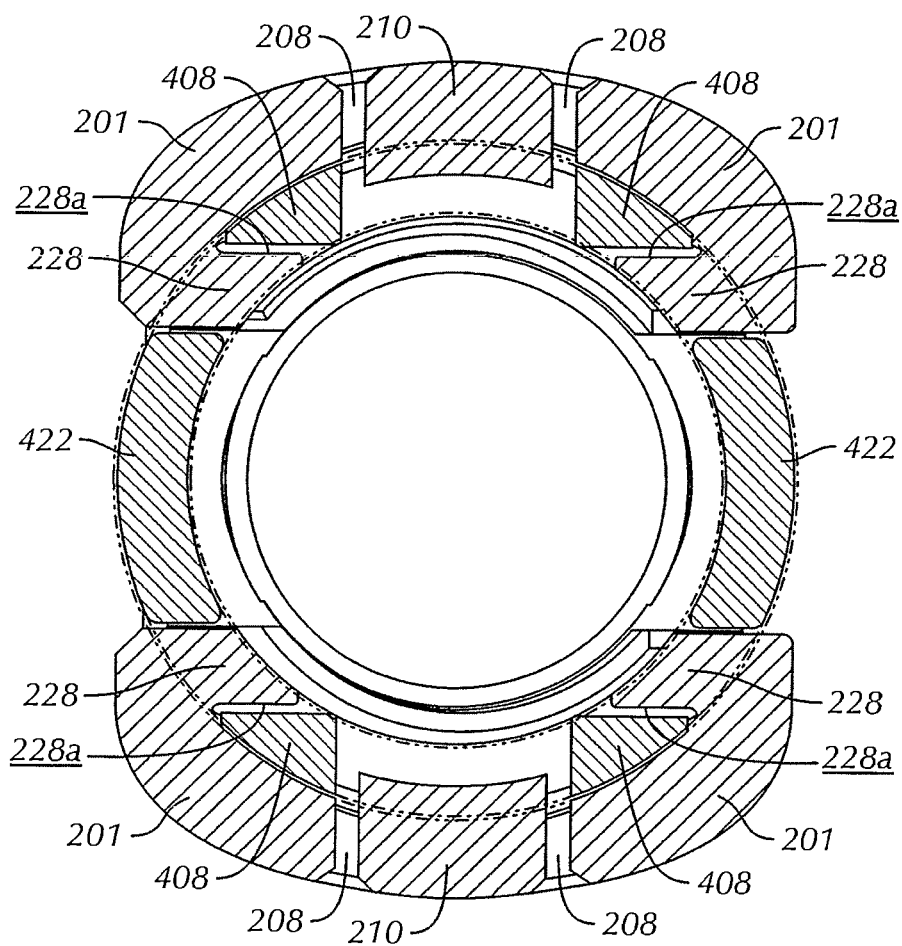


FIG. 9

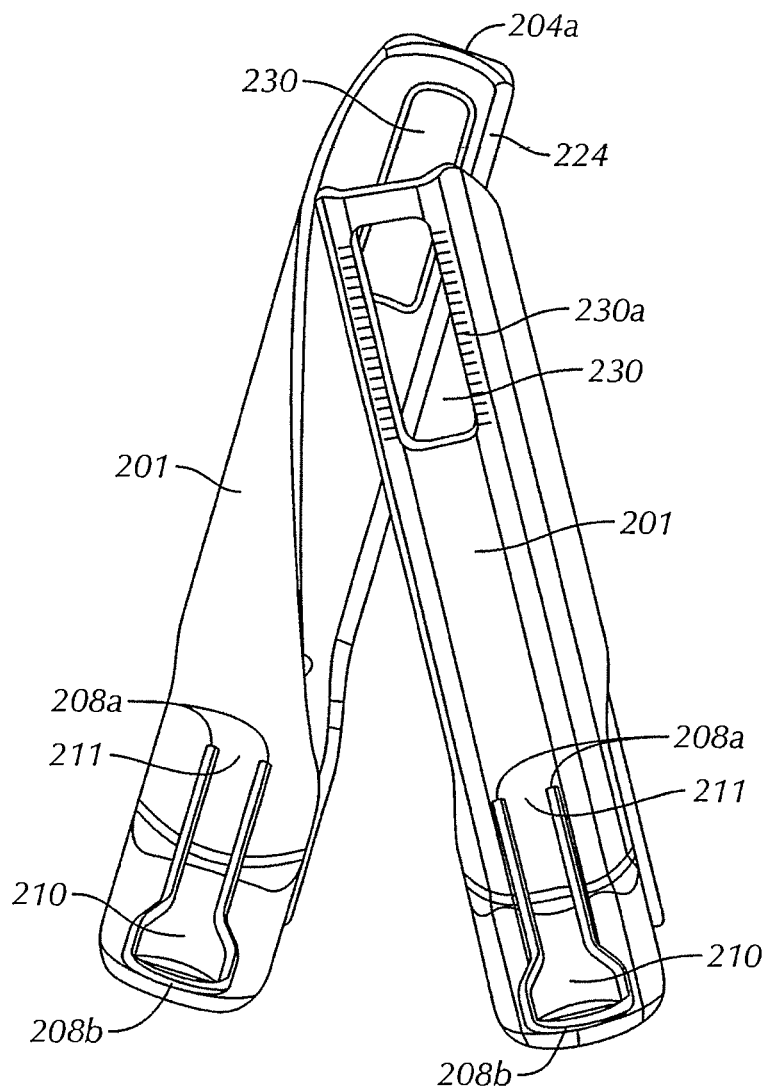


FIG. 10A

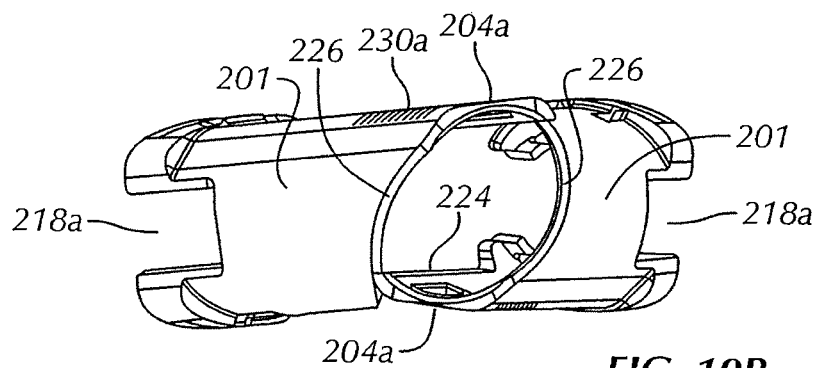


FIG. 10B

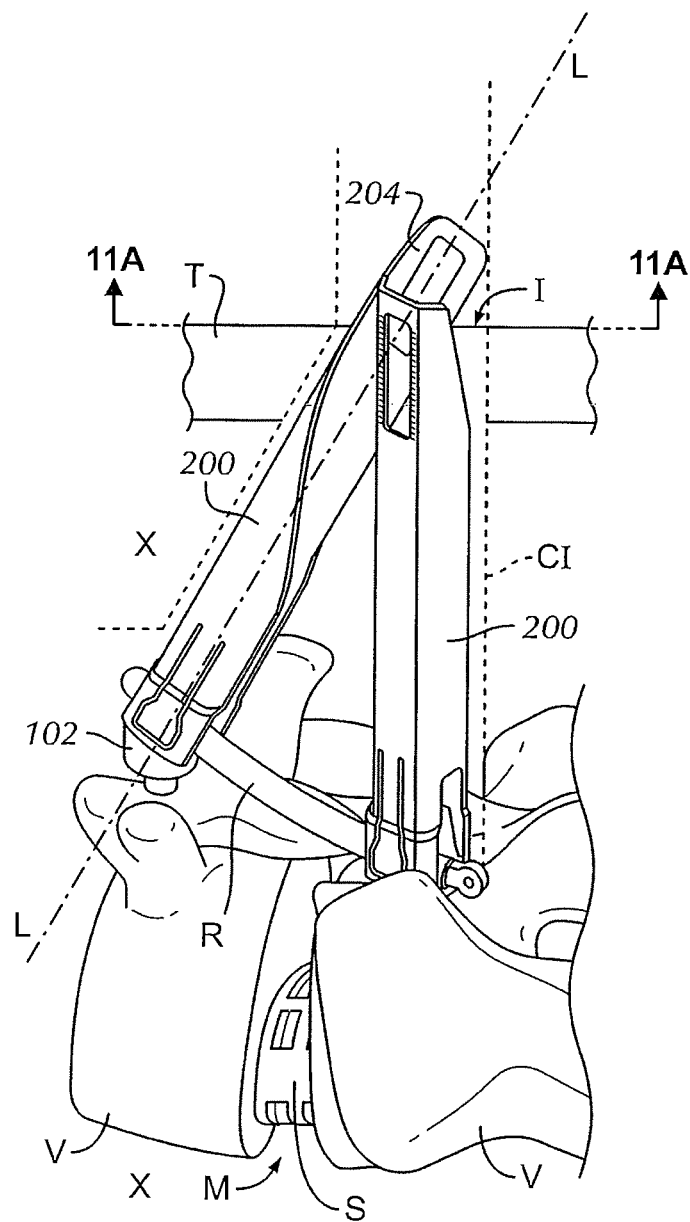


FIG. 10C

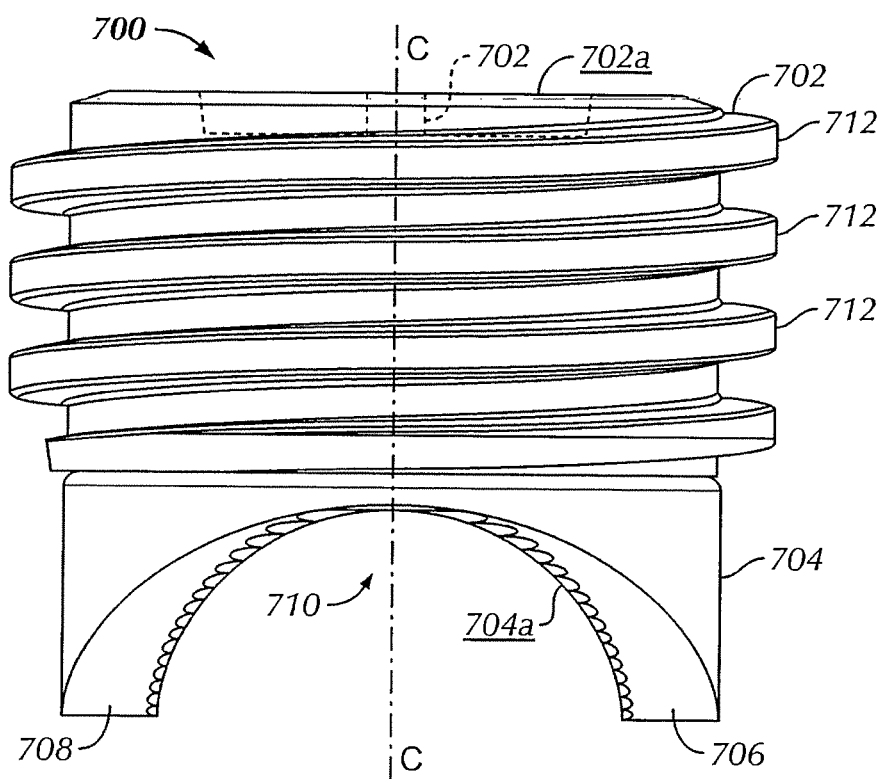


FIG. 11

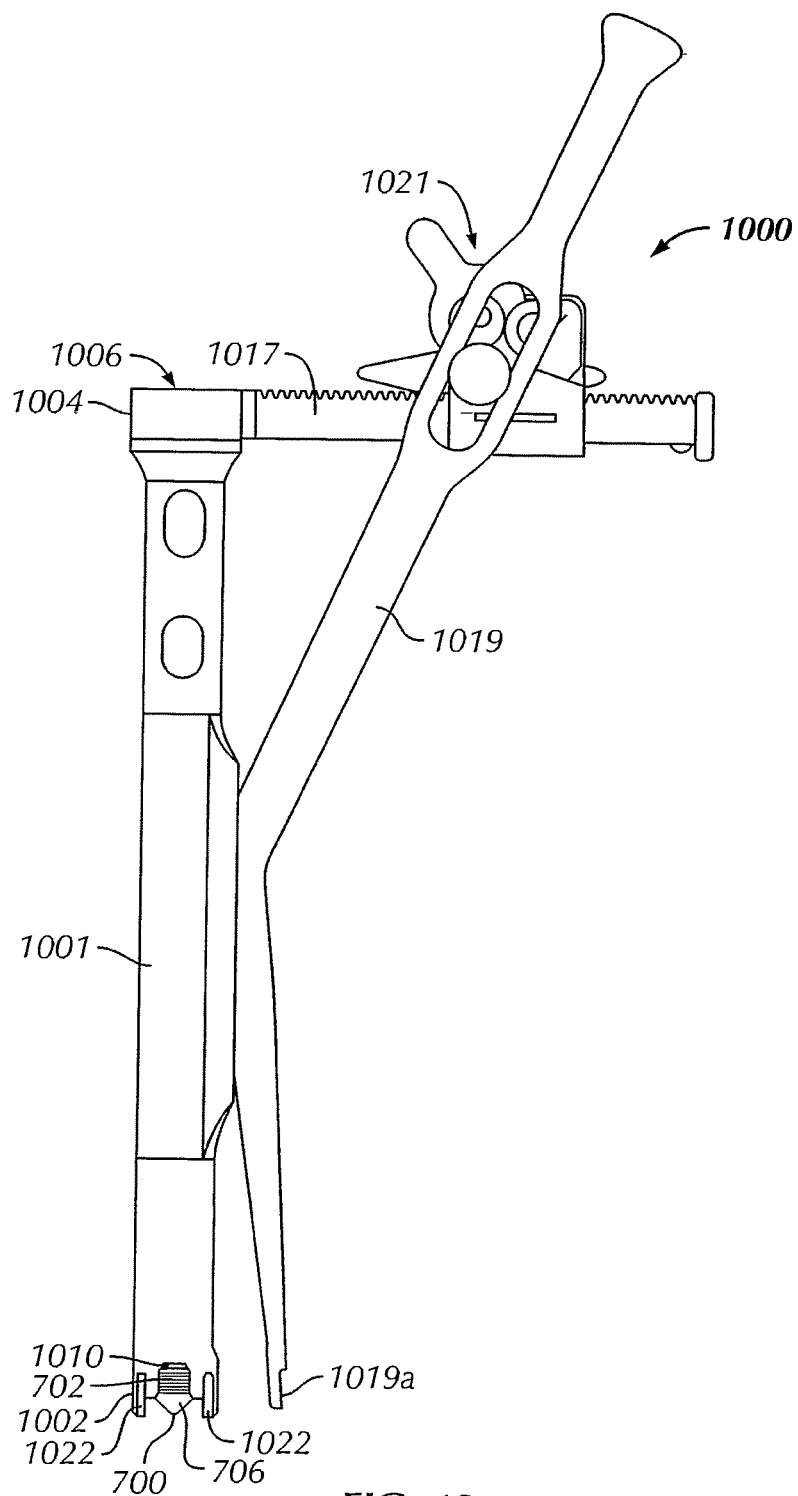


FIG. 12

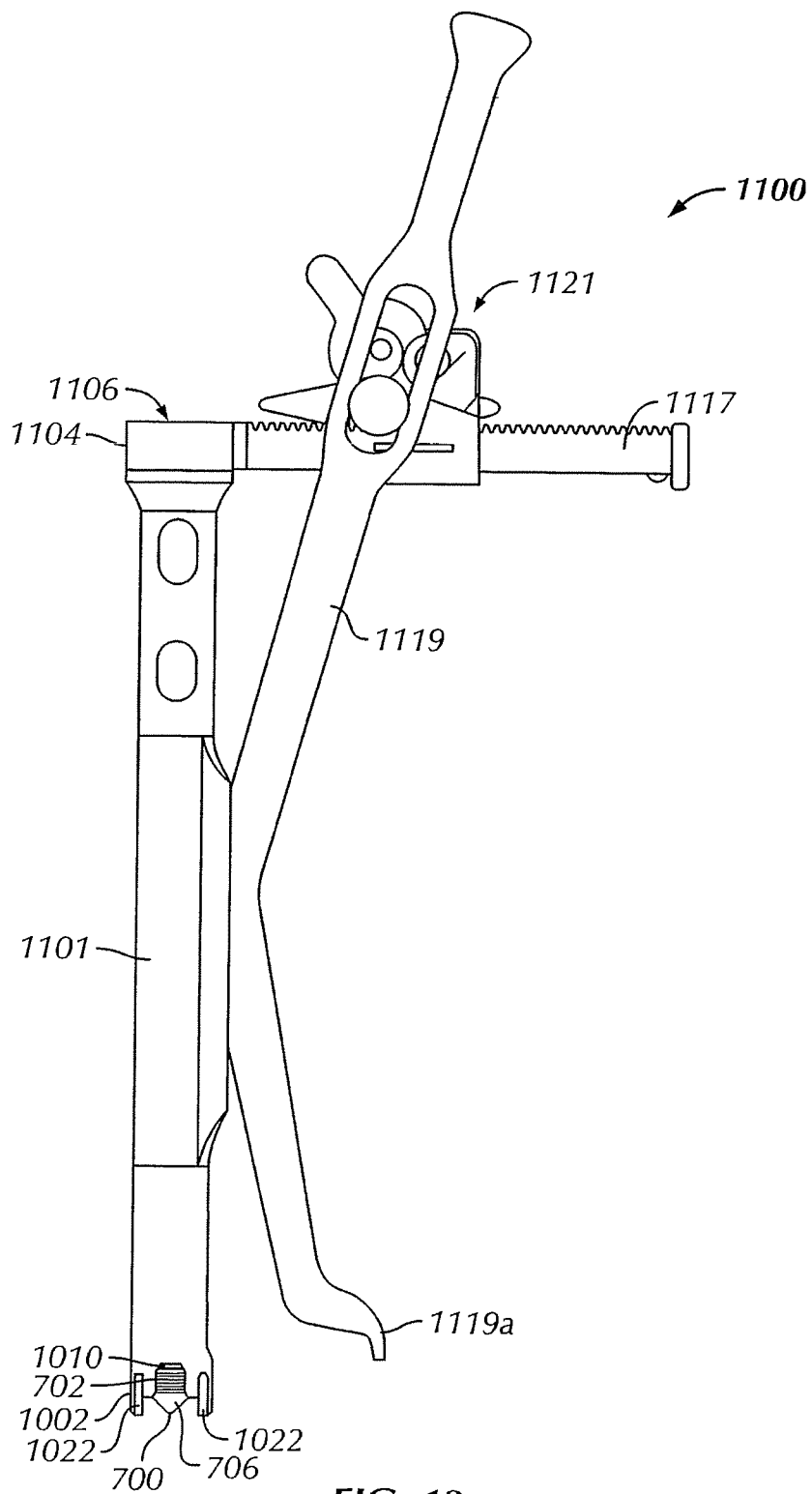


FIG. 13

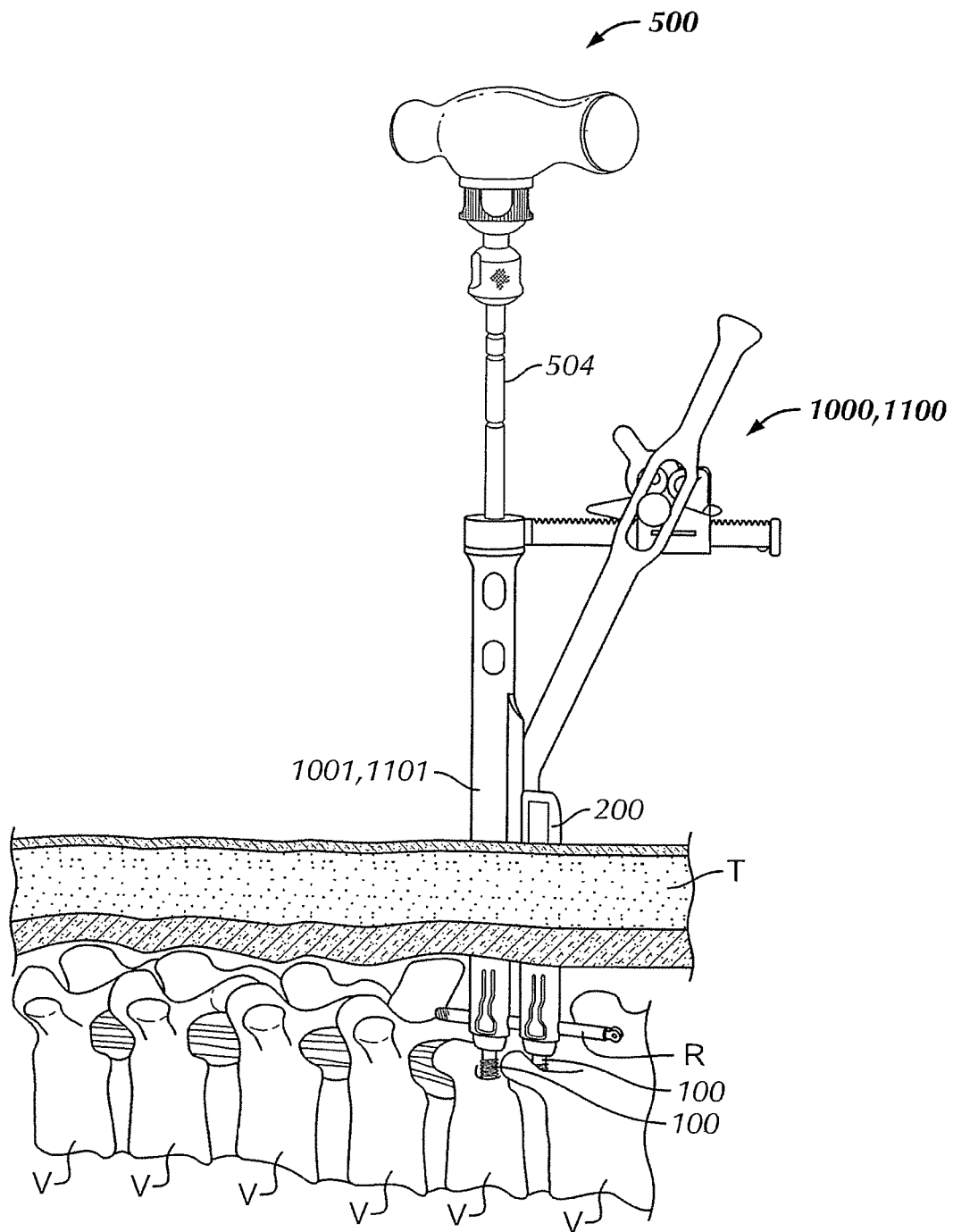


FIG. 14

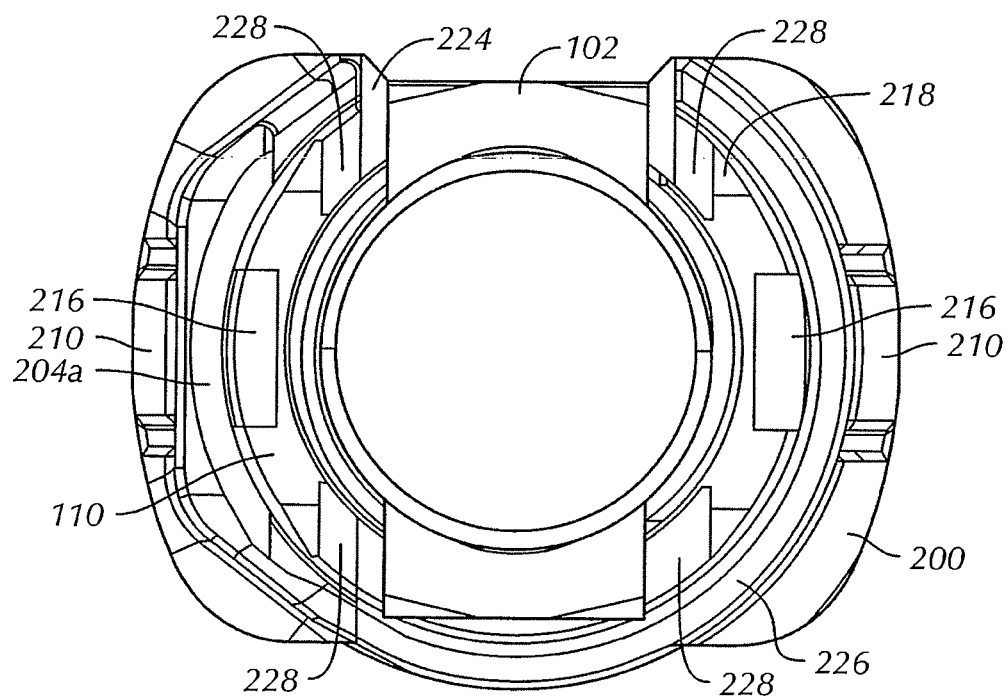


FIG. 15

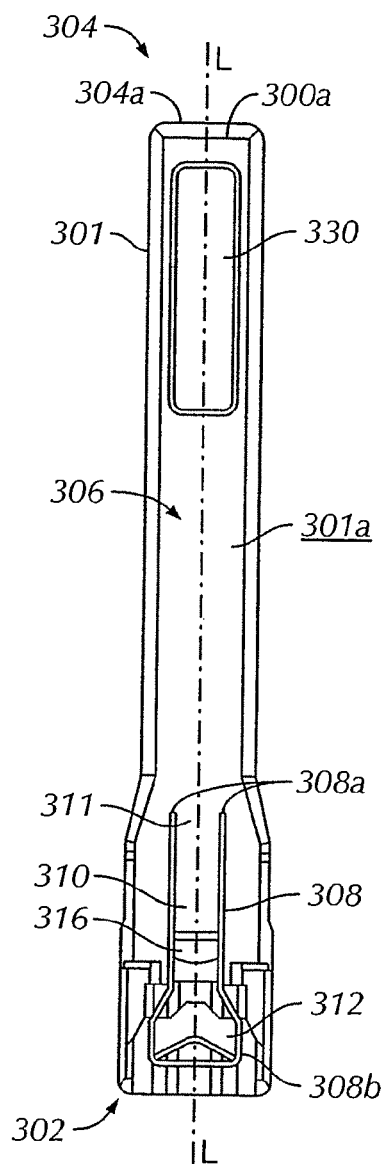


FIG. 16

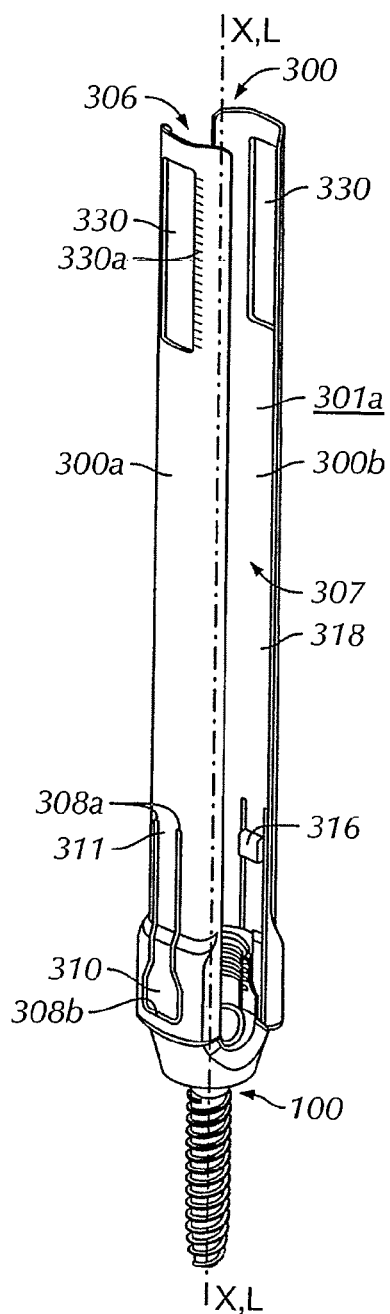


FIG. 17

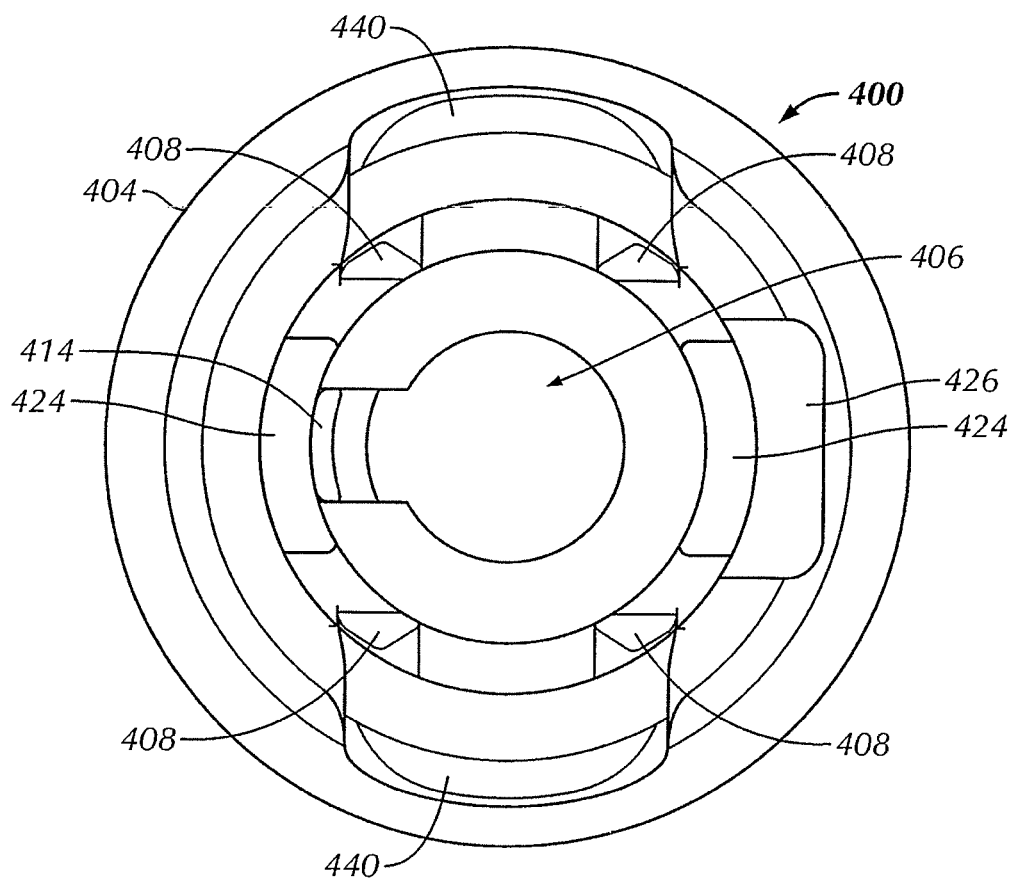
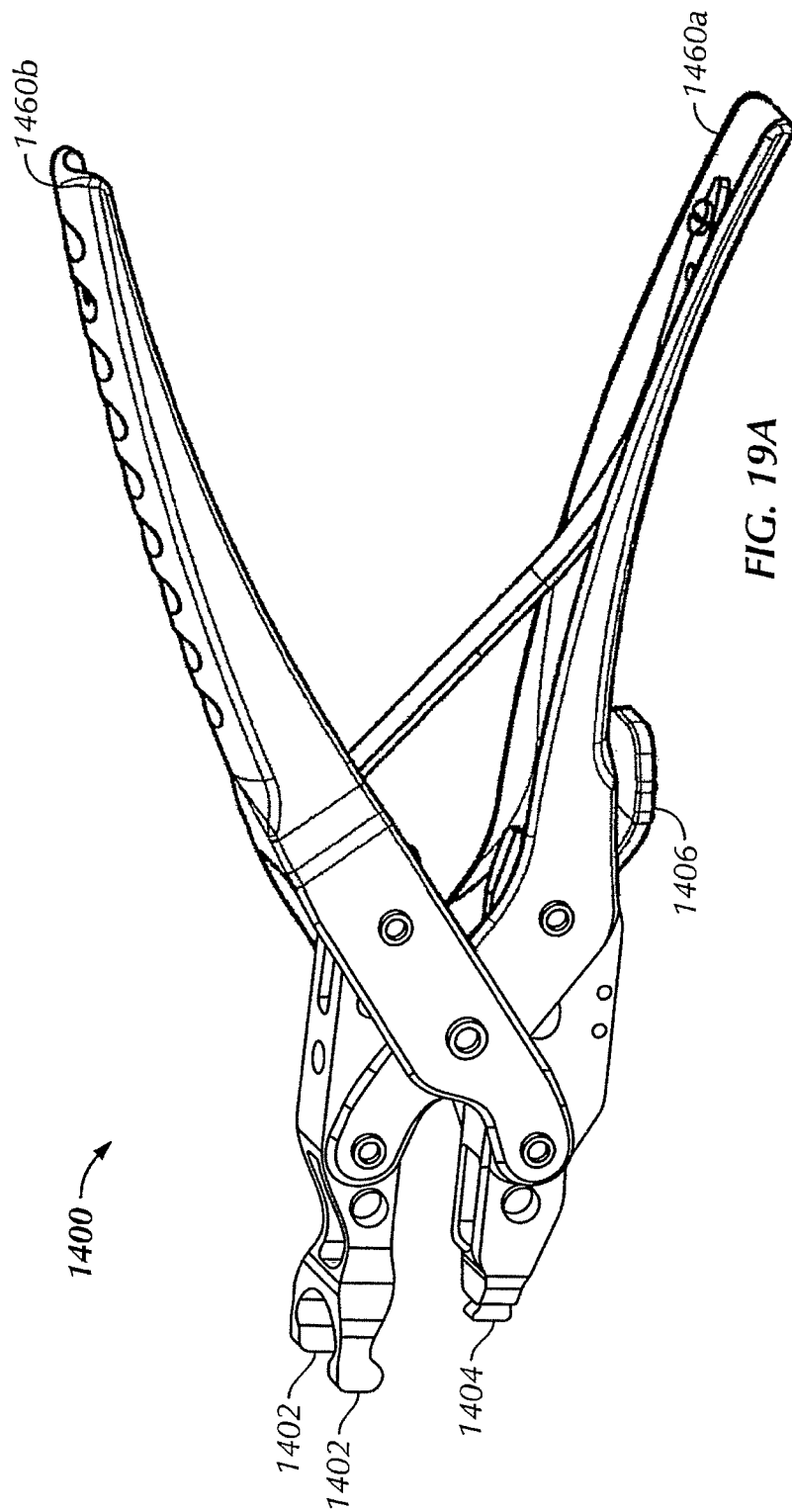
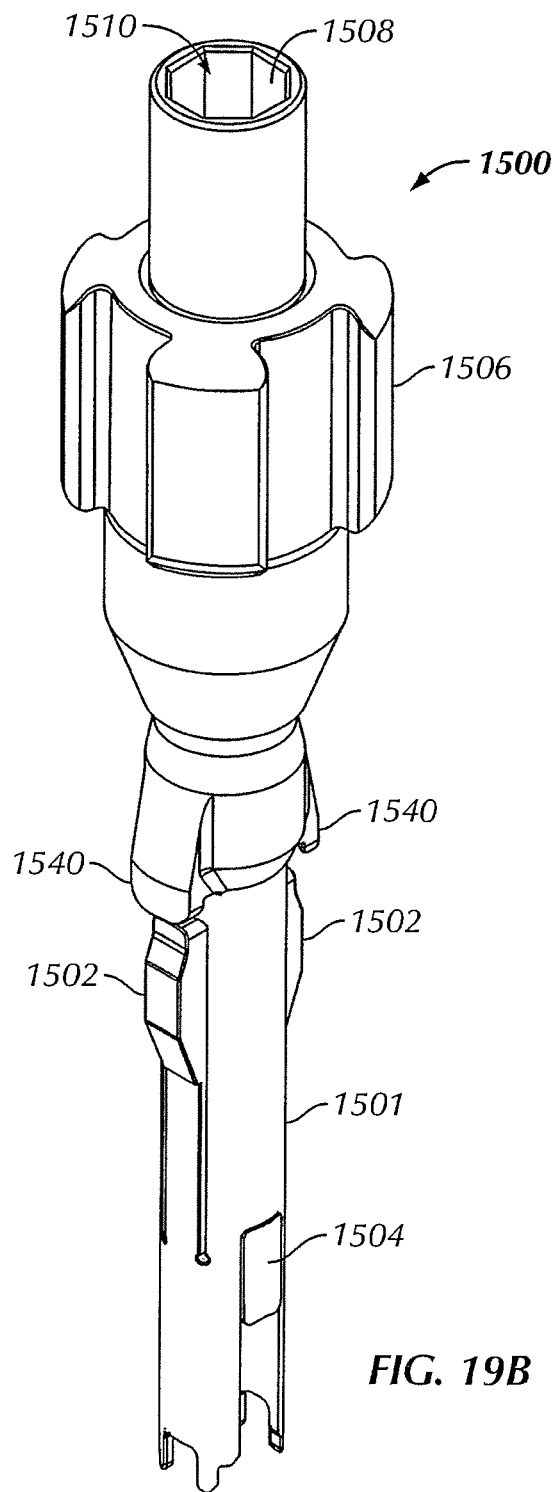


FIG. 18





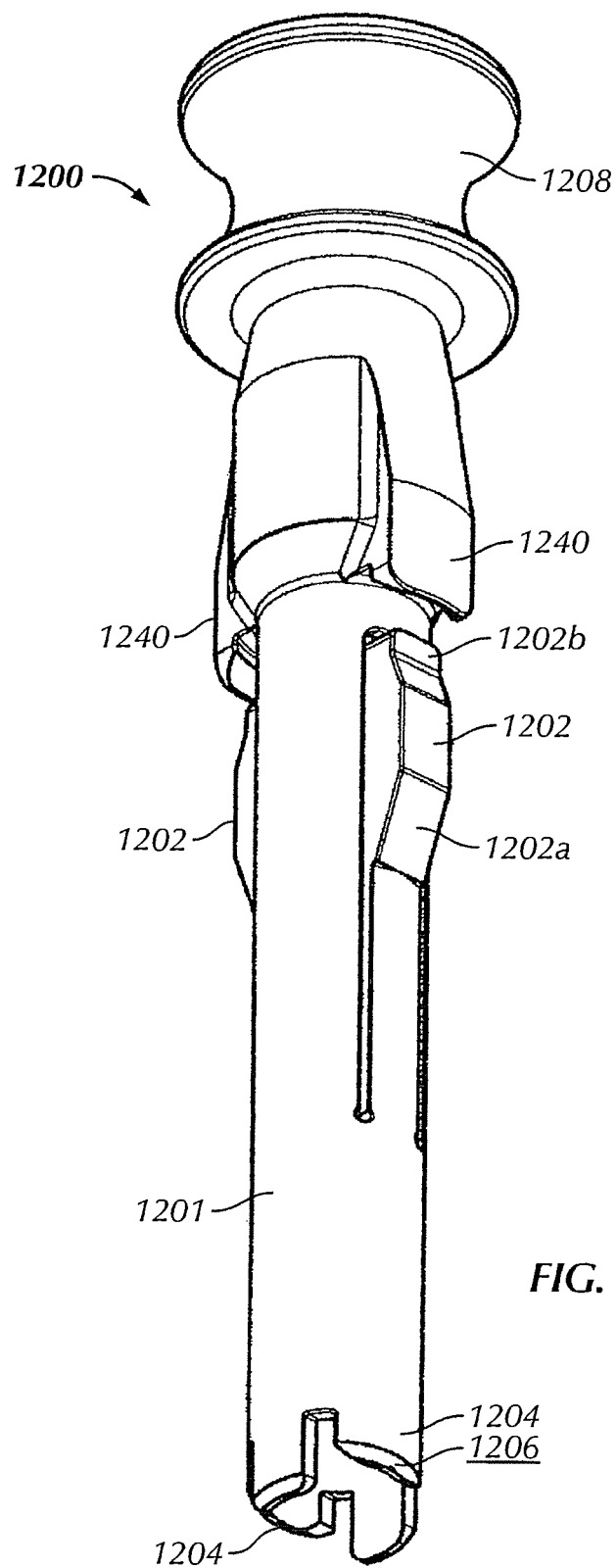
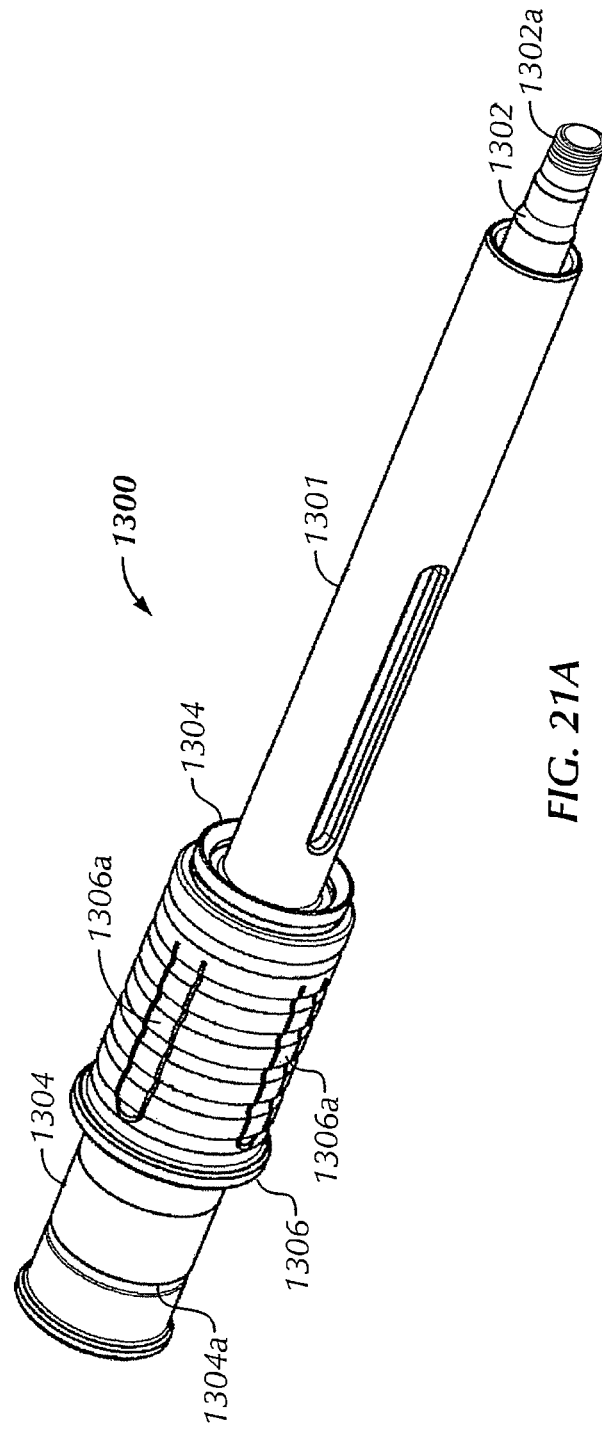


FIG. 20



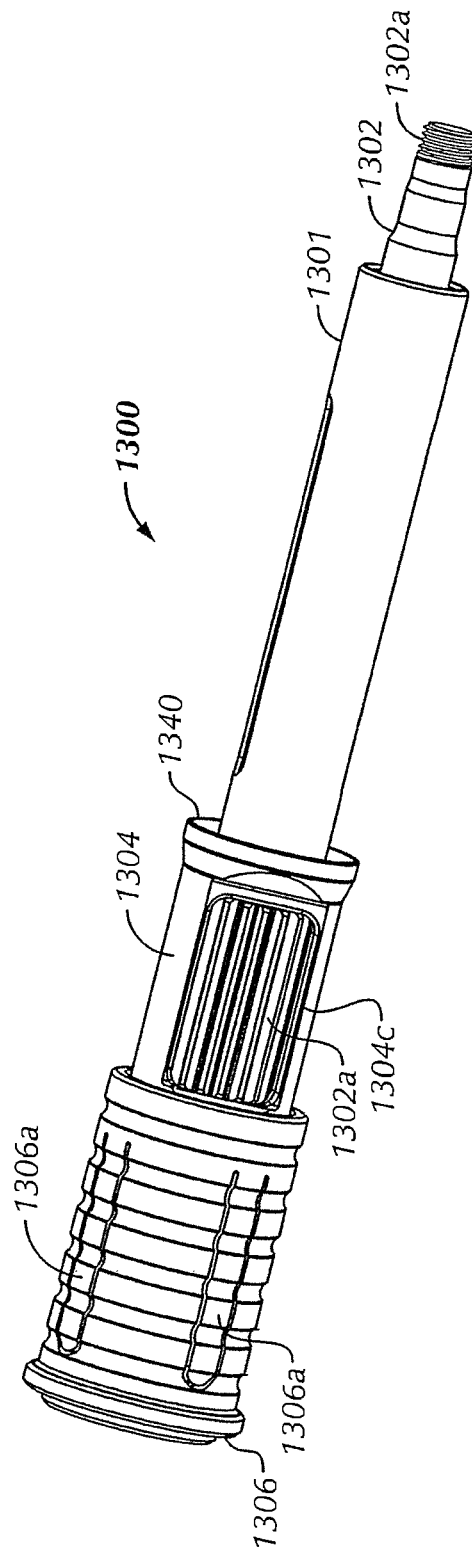


FIG. 21B

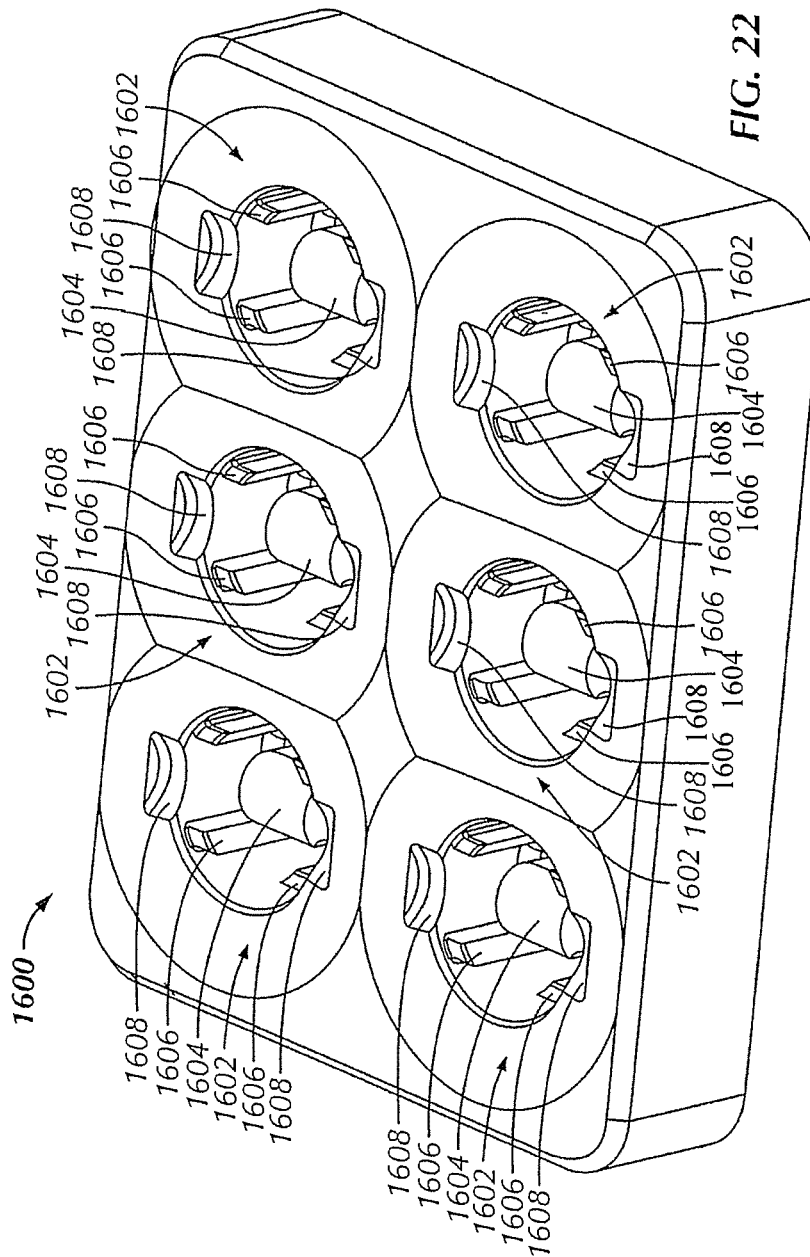


FIG. 22

1

MINIMALLY INVASIVE INSTRUMENT SET, DEVICES AND RELATED METHODS

CROSS REFERENCE TO RELATED APPLICATIONS

This application is a division of U.S. application Ser. No. 12/766,393, filed Apr. 23, 2010, the contents of which are hereby incorporated by reference herein as if set forth in their entirety.

BACKGROUND

Retractors provide a surgeon with an access portal or pathway to a surgical site, for example during spine surgeries such as discectomies, laminectomies, facetectomies, interbody fusions, pedicle screw fixation and similar procedures. Traditional spine surgeries were conducted utilizing an open procedure resulting in a relatively large incision, disruption or resection of significant soft tissue and long recovery times for patients. Minimally invasive techniques have become increasingly popular, particularly for spine surgeries, wherein relatively small incisions and surgical pathways are utilized to perform surgical procedures on a patient, generally resulting in a smaller incision or several relatively small incisions, less retraction and resection of soft tissue and shorter recovery times for patients in comparison to open procedures. Minimally invasive procedures are, in certain circumstances, able to obtain comparable or improved long term surgical outcomes in comparison to open procedures and may provide short term benefits including reduced post-operative pain, reduced use of post-operative narcotics, reduced tissue disruption, thereby permitting reduced scar tissue and potential benefits if a revision is necessary, reduced blood loss, accelerated recovery time, shorter hospital stays and cosmetically appealing smaller incisions. However, the smaller incision or incisions diminish the line-of-sight for a surgeon to directly view a surgical site, because patient soft tissue often limits a surgeon's ability to view the surgical site.

A common procedure in spine surgeries involves fixing screws to several vertebra and securing the screws and vertebra relative to each other with a rod. Such spinal constructs are typically implanted by mounting enclosed or substantially enclosed cannulae or sleeves to the screws such that the enclosed cannulae or sleeves create a surgical pathway through soft tissue and provide access for the surgeon to the surgical site. Minimally invasive spine instruments utilized for such procedures can be difficult to assemble, limit a surgeon's ability to view the surgical site, are bulky and extend a significant distance out of a patient's skin, may detach from the screws during the procedure, are complicated to operate involving many steps, result in procedures involving removal and replacement of multiple instruments, inhibit imaging utilizing a C-arm or Fluoroscope as a result of their size and material composition and may be difficult to detach from the screws at the conclusion of the procedure. In addition, current minimally invasive fixation of screws and placement of rods in spine surgery often result in undesirable levels of trauma to a patient's soft tissue in and around the surgical site, along the surgical pathway and proximate the incision. Once assembled for rod insertion, these conventional minimally invasive systems are typically locked into a predetermined position and inhibit a surgeon's options in adapting their surgical technique to a particular patient's anatomy or in adapting the instruments to implant the components in a manner that would benefit the patient.

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Certain conventional, minimally invasive spine instrumentation for the placement of pedicle screws and rods is bulky and complicated to utilize with multiple tool exchanges and complicated steps in mounting, removing, aligning and otherwise manipulating the bulky instrumentation to secure screws in the vertebrae and fix the rod to the implanted screws. A surgeon is often unable to directly visualize the surgical site, the screws and/or the rods once they are implanted in a patient, because of the bulky instruments and the relatively small size of the surgical incisions. Accordingly, a surgeon often relies on fluoroscopy to verify that screws and rods are properly placed in a patient and are securely fixed together. Accurate intra-operative visualization of the implant construct can be difficult for a spine surgeon to verify with fluoroscopy because the relatively bulky metallic instruments attached to the construct are radio-opaque.

In addition, the complicated procedures and instrumentation utilized with certain minimally invasive spine surgeries often require removal and replacement of different instruments through the enclosed cannulas or sleeves, thereby fatiguing a surgeon and extending the time that a patient is in surgery and subjected to anesthesia. Further, complicated procedures and instrumentation can lead to surgical delays, particularly for newly trained or novice surgical staff and surgeons when deciphering the complicated procedures and instrumentation. For example, certain counter-torque tools have been specially designed to fit within or onto minimally invasive spinal cannulas or sleeves that may result in several tool exchanges to tighten locking caps onto spinal rods. Further, the grasping handle of the counter-torque tool of conventional minimally invasive spine surgical sets can impede the surgeons visibility or prevent the use of other instruments during the procedure. Further, locking caps are often introduced through and into the substantially enclosed sleeves or cannulae of conventional systems with a screwdriver that must be removed from the sleeve or cannula several times during the procedure to introduce instruments such as the counter-torque sleeve, a distractor, a compressor or similar instruments. The screwdriver typically has a self-retaining tip that has a limited ability to retain the locking cap if the sides of the sleeve or cannula are impacted with the locking cap, resulting in the locking cap becoming detached and falling into the incision, thereby requiring removal of the screwdriver and retrieval of the locking cap through the sleeve or cannula or through one of the minimal incisions. Accordingly, it would be desirable to construct a minimally invasive spine instrument set with a counter-torque tool that is relatively easy to secure to a screw for tightening of a locking cap and is relatively easy to remove and replace so that the instrument is only in the theatre when necessary for tightening purposes. It is also desirable to design and construct an instrument set that permits insertion of the locking cap into a minimally invasive incision utilizing a more robust retaining feature than the self-retaining tip of a screwdriver.

Further, conventional minimally invasive instrument sets often have an unwieldy number of excess protruding parts proximate the incision, often for the purpose of fixing the retractor to the polyaxial bone screw, that can block the surgeon's view of the site. Such unwieldy parts severely inhibit a surgeon's ability to visualize the construct at the surgical site and result in generally blind insertion and significant reliance on the instrumentation. Coupled with the metallic composition and bulky size of the instruments, visualization of the construct may not be possible until all of the instruments are removed from the construct and the incision at the conclusion of the procedure. Subsequently, if the finally implanted con-

struct is not acceptable to the surgeon, the bulky and unwieldy instruments may have to be reattached to the construct or the surgeon may need to repair the construct through an open procedure.

The conventional minimally invasive spine instruments are typically bulky and unwieldy to react forces encountered by the relatively long, hollow sleeves or cannulae during final tightening of the locking caps to the pedicle screws. The hollow sleeves or cannulae are typically bulky and stiff specifically at the distal end portions to rigidly hold the arms of the pedicle screws in position during final tightening to prevent splaying of the pedicle screws under final tightening loads. In addition, the hollow sleeve or cannulae are bulky and unwieldy along their length to prevent twisting, splaying or breakage during the final tightening step. This metallic bulk attached to the construct limits visualization, as was described above.

BRIEF SUMMARY

It would be desirable to develop a minimally invasive spine instrument set that is relatively simple, utilizes relatively small components that improve fluoroscopic visualization of the screws and rod when the instruments are attached thereto and are relatively low-profile at the skin incision to permit maximum line-of-sight potential for the surgeon. It would also be desirable to construct a minimally invasive spine instrument set with a counter-torque tool that is relatively easy to secure to a screw for tightening of a locking cap and is relatively easy to remove and replace so that the instrument is only in the surgical theatre when necessary for tightening purposes. In addition, it is desirable to design and construct an instrument set that permits insertion of the locking cap into a minimally invasive incision utilizing a more robust retaining feature than the self-retaining tip of a screwdriver. Further, it is desirable to design and construct a set of minimally invasive instruments that enhances a surgeon's line-of-sight during the procedure or while mounted to the construct and permits visualization utilizing fluoroscopy while the instruments are mounted to the construct. It is also desirable to construct a minimally invasive spine instrument set that maximizes visualization by reducing the bulk of the instruments without compromising strength during the final tightening step and preventing splaying of the instruments or the pedicle screws. It is further desirable to design and construct a system for minimally invasive spine surgery that allows for simple coupling and decoupling of a tissue retractor to and from the bone anchor or pedicle screw, eliminates excessive field-of-view blocking instrumentation, minimizes the incision, and limits splay and cross-threading while reducing excess tool replacement, thereby simplifying the surgical procedure.

Briefly stated, an exemplary instrument set for use in minimally invasive spine surgery includes a polyaxial bone screw and a tissue retractor having distal and proximal end portions and a partial pathway formed therebetween. The tissue retractor is removably couplable to the bone anchor and rotatably fixed to the bone anchor when coupled thereto. An instrument has distal and proximal end portions and a hollow cavity formed therebetween, and is removably couplable within the partial pathway of the tissue retractor and rotatably fixed to the tissue retractor when coupled thereto. A drive shaft has a diameter that is less than a diameter of the hollow cavity of the instrument and is rotatable with respect to the instrument when positioned therein. A counter-torque handle has a gripping end portion and an interlock end portion. The interlock end portion includes an instrument interface that is releasably positioned within the hollow cavity of the instrument at the

proximal end portion thereof and is rotatably fixed thereto in an assembled configuration. The interlock end portion also includes an open-ended slot having a width that is greater than the diameter of the drive shaft such that the counter-torque handle is movable to and from the assembled configuration while the drive shaft is within the hollow cavity.

Another exemplary embodiment of the instrument set for performing minimally invasive spine surgery includes a polyaxial bone screw and a tissue retractor having a distal end portion configured to receive and removably couple to the polyaxial bone screw, a proximal end portion opposite the distal end portion, and a partial pathway formed at the distal end portion and extending toward the proximal end portion. The distal end portion of the tissue retractor includes a blocking rib projecting into the partial pathway of the tissue retractor and having an inner surface. An instrument has distal and proximal end portions and a hollow cavity formed therebetween. The instrument is received within the partial pathway of the tissue retractor in an assembled configuration such that the partial pathway of the tissue retractor and the hollow cavity of the instrument are coaxially aligned. The distal end portion of the instrument includes a blocking tab that is received by the blocking rib of the tissue retractor in the assembled configuration. The blocking tab contacts the inner surface of the blocking rib in the presence of a force exerted by the bone screw on an interior surface of the tissue retractor.

A further exemplary embodiment of an instrument set for performing minimally invasive spine surgery includes a polyaxial bone screw having a body and a bone screw. The body has a rod channel with a rod receiving portion disposed proximate the bone screw and a threaded portion distally located from the bone screw. A tissue retractor has a proximal end portion, a distal end portion, and a partial pathway extending longitudinally from the distal end portion toward the proximal end portion. The distal end portion is removably coupled to the body of the polyaxial bone screw. A locking cap has a threaded portion. A cap guide has a proximal end portion, a distal end portion, and a hollow cavity extending longitudinally therebetween. The locking cap is removably insertable into the hollow cavity of the cap guide and rotatable with respect to the cap guide when positioned therein. The cap guide is positioned within the partial pathway of the tissue retractor in the assembled configuration such that the partial pathway of the tissue retractor and the hollow cavity of the cap guide are coaxially aligned and the locking cap is coaxially aligned with the body of the polyaxial bone screw to permit mating of the threaded portion of the locking cap with the threaded portion of the body.

A still further exemplary embodiment of an instrument set for use in minimally invasive spine surgery includes a bone anchor having an outer surface with at least one recess. A tissue retractor is removably coupled to the bone anchor in an assembled configuration and includes a body having a proximal end portion and a distal end portion defining a longitudinal axis therebetween, a partial pathway extending longitudinally between the proximal and the distal end portions, a window accessing the partial pathway and formed in the body proximate the proximal end portion, and at least one cutout slot in the body extending generally longitudinally along a portion of the body proximate the distal end portion. The at least one cutout slot has proximal and distal end portions. A resiliently movable arm is defined by the at least one cutout slot, is movably attached to the body at the proximal end portion of the at least one cutout slot, and has an attachment tab projecting generally transverse to the longitudinal axis adjacent the distal end portion of the at least one cutout slot and a protrusion projecting generally transverse to the longi-

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tudinal axis adjacent the proximal end portion of the at least one cutout slot. The at least one tab is positioned within the at least one recess when the bone anchor and tissue retractor are in the assembled configuration. A removal tool has proximal and distal end portions and is received within the partial pathway of the tissue retractor in an engaged position. The removal tool includes a body having a proximal end portion and a distal end portion and at least one protrusion extending from the removal tool body proximate the distal end portion. The at least one protrusion is configured to engage the corresponding protrusion of the resiliently movable arm of the tissue retractor in the engaged position to cause the tab of the resiliently movable arm to be spaced apart from the recess of the bone anchor. A resilient tab is disposed proximate the proximal end portion of the removal tool body. The resilient tab has (1) a relaxed position wherein when the tissue retractor and removal tool are in the engaged position, the resilient tab projects from the body of the removal tool and is positioned within the window of the tissue retractor, rotatably fixing the tissue retractor and the removal tool to permit removal of the tissue retractor from the bone anchor, and (2) a depressed position wherein the resilient tab is depressed toward the body of the removal tool to permit insertion or removal of the removal tool from the partial pathway of the tissue retractor.

BRIEF DESCRIPTION OF THE SEVERAL VIEWS OF THE DRAWINGS

The foregoing summary, as well as the following detailed description of the device and method, will be better understood when read in conjunction with the appended drawings. For the purpose of illustrating the device and method of the present application, there is shown in the drawings exemplary embodiments. It should be understood, however, that the exemplary device and method are not limited to the precise arrangements and instrumentalities shown. In the drawings:

FIG. 1 is a top perspective view of a first exemplary embodiment of a bone anchor assembly or polyaxial pedicle screw without a locking cap (See FIG. 11) for use with an exemplary embodiment of a minimally invasive instrument set;

FIG. 2 is a front elevational view of the bone anchor assembly or polyaxial pedicle screw of FIG. 1;

FIG. 3 is a side perspective view of a tissue retractor in accordance with the exemplary embodiment of the instrument set;

FIG. 4 is a side perspective view of the tissue retractor of FIG. 3 with resiliently movable arms thereof in a flexed position;

FIG. 5 is a side perspective view of the pedicle screw of FIG. 1 coupled to the tissue retractor of FIG. 3;

FIG. 6A is a right-side perspective view of a cap guide instrument in accordance with the exemplary embodiment of the instrument set;

FIG. 6B is a left-side perspective view of the cap guide instrument of FIG. 6A;

FIG. 7 is a top perspective view of a counter-torque handle in accordance with the exemplary embodiment the instrument set;

FIG. 8 is a side perspective view of the pedicle screw of FIG. 1, the tissue retractor of FIG. 3, the cap guide instrument of FIG. 6A, the counter-torque handle of FIG. 7, and a screwdriver in an assembled or working configuration in accordance with the exemplary embodiment the instrument set;

FIG. 9 is an enlarged cross-sectional view of the cap guide instrument of FIG. 6A coupled to the tissue retractor of FIG.

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3, taken along line 9-9 of FIG. 8 with only portions of the cap guide instrument and tissue retractor shown for clarity;

FIG. 10A is a side perspective view of two tissue retractors of FIG. 3 in a partially nested configuration;

FIG. 10B is a top perspective view of the two tissue retractors of FIG. 11A;

FIG. 10C is a side perspective view of the two tissue retractors of FIG. 3 and two bone anchors of FIG. 1 secured to adjacent vertebrae in a surgical procedure;

FIG. 11 is a greatly enlarged front elevational view of the exemplary locking cap of the pedicle screw of FIG. 1 in accordance with the exemplary embodiment;

FIG. 12 is a front elevational view of a distractor in accordance with the exemplary embodiment the instrument set with the locking cap of FIG. 11 mounted therein;

FIG. 13 is front elevational view of a compressor in accordance with the exemplary embodiment the instrument set with the locking cap of FIG. 11 mounted therein;

FIG. 14 is a side elevational view of pedicle screws of FIG. 1 and tissue retractors of FIG. 11 further including the distractor or compressor of FIG. 12 or 13, a rod, and a screwdriver in accordance with the exemplary instrument set arranged for a surgical procedure;

FIG. 15 is a greatly enlarged top plan view of a body of the polyaxial bone screw of FIG. 1 coupled to the tissue retractor of FIG. 3;

FIG. 16 is a side elevational view of one component of a two-piece tissue retractor for use with the exemplary embodiment of the instrument set;

FIG. 17 is a side perspective view of the two-piece tissue retractor of FIG. 16 coupled to the pedicle screw of FIG. 1;

FIG. 18 is a greatly enlarged bottom plan view of the cap guide instrument of FIG. 6;

FIG. 19A is a side perspective view of a scissor persuader in accordance with the exemplary embodiment of the instrument set;

FIG. 19B is a side perspective view of a threaded persuader in accordance with the exemplary embodiment of the instrument set;

FIG. 20 is a side perspective view of a removal tool in accordance with the exemplary embodiment of the instrument set;

FIG. 21A is a side perspective view of a screw holder in accordance with the exemplary embodiment of the instrument set;

FIG. 21B is a side perspective view of the screw holder of FIG. 21A with a safety shield in an actuating position; and

FIG. 22 is a top perspective view of a cap tray for holding several of the locking caps of FIG. 11 in accordance with the exemplary embodiment of the instrument set.

DETAILED DESCRIPTION

Certain terminology is used in the following description for convenience only and is not limiting. The words "right," "left," "lower," and "upper" designate directions in the drawings to which reference is made. The words "inwardly" or "distally" and "outwardly" or "proximally" refer to directions toward and away from, respectively, the geometric center or orientation of the exemplary instrument set and related parts thereof. The words, "anterior," "posterior," "superior," "inferior," "lateral," "medial," and related words and/or phrases designate exemplary positions and orientations in the human body to which reference is made and are not meant to be limiting. The terminology includes the above-listed words, derivatives thereof and words of similar import.

FIGS. 1, 2 and 11 show an exemplary bone anchor assembly, polyaxial bone screw or polyaxial pedicle screw **100** for use with an exemplary instrument set for minimally invasive spine surgery includes a body **102**, a locking cap or a bone screw cap **700** and a threaded portion or bone screw **104**. Although the figures and description of the present application show and describe the exemplary polyaxial bone screw **100**, it will be apparent to one having ordinary skill in the art based upon a review of the present disclosure that the exemplary instrument set may be modified and adapted to function with a monoaxial bone screw (not shown). The exemplary instrument set may also be adapted to operate and function with numerous styles of pedicle screws and is not limited to functioning with the exemplary pedicle screw **100**.

The bone screw **104** includes a plurality of threads **106** for securing the polyaxial pedicle screw **100** to a vertebra V (FIG. 14) of a patient. The body **102** is polyaxially mounted to the bone screw **104** such that the bone screw **104** is rotatable and pivotable with respect to the body **102**. A locking collar or collet **101** is mounted within the body **102** and is positioned between the body **102** and a head of the bone screw **104** in an assembled configuration. The locking collar **101** facilitates the polyaxial movement of the bone screw **104** relative to the body **102** and locking of the body **102** relative to the bone screw **104** in a locked configuration. An example of a polyaxial bone screw **100** that may be utilized with the exemplary minimally invasive instrument set is described in International Patent Application Publication No. WO 2009/015100 ("WO 100"), titled, "Polyaxial Bone Fixation Element" and filed, Jul. 21, 2009, which is incorporated herein by reference in its entirety.

The polyaxial bone screw **100** is generally constructed of titanium or a titanium alloy, such as an alloy including Titanium, Aluminum and Niobium (TAN—TI-6Al-6Nb—ASTM F 1295) but may also be constructed of stainless steel, other metallic alloy materials or nearly any strong, stiff, biocompatible material that is able to take on the general size and shape of the polyaxial bone screw **100** and withstand the normal operating conditions of the polyaxial bone screw **100**. The polyaxial bone screw **100**, particularly the bone screw **104**, may be provided having different lengths and/or diameters to accommodate anatomical variations and bone structure of specific patients. The bone screw **104** may be cannulated (not shown) along a central longitudinal screw axis X-X thereof for positioning and placement of the polyaxial bone screw **100** over a Kirschner wire or guide wire (K wires) (not shown) for guidance of the bone screw **104** to the site of implantation on the vertebra V.

The body **102** includes a generally U-shaped rod slot or channel **108** defined by two arms **110**. The collet **101** includes a rod saddle **101a** that is aligned with the rod channel **108** in an assembled configuration and receives and contacts a spinal rod R (FIG. 10C) in a locked configuration. The rod channel **108** terminates proximate the collet **101** in an assembled configuration to form a rod receiving portion **112** that is sized to accommodate the rod R (FIG. 10C). Each arm **110** includes an interior surface **110a** having a threaded portion **114** located distally from the bone screw **104** in the assembled configuration. An outer surface **110b** of each arm **110** typically includes a recess **116** therein.

Referring to FIGS. 1-5, 9 and 10A-10C, a tissue retractor **200** of the exemplary instrument set for minimally invasive spine surgery for use with the bone anchor assembly **100** includes a body **201** with a distal end portion **202**, a proximal end portion **204** and a longitudinal tissue retractor axis L-L extending between the distal and proximal end portions **202**, **204**. The body **201** includes first and second slots **218a**, **218b**

at the distal end portion **202** and first and second longitudinally extending edges **224**, **226** that define the second slot **218b** at the distal end portion **202**. The longitudinally extending edges **224**, **226** extend between the distal and proximal end portions **202**, **204**. The first longitudinally extending edge **224** is generally parallel with the longitudinal tissue retractor axis L-L of the tissue retractor **200**, but is not so limited and may extend in nearly any path or include changes in direction along its length to adapt the design of the tissue retractor **200** to particular applications. The second longitudinally extending edge **226** is generally parallel with the longitudinal tissue retractor axis L-L at the distal end portion **202** and curves in a helix-like shape from an inflection point **217** near the distal end portion **202** toward the proximal end portion **204** such that the tissue retractor **200** has less structure than an enclosed or substantially enclosed cannula or sleeve. In this manner, the tissue retractor **200** may provide a more forgiving line-of-sight to a surgeon at a skin incision I and to limit material of the tissue retractor **200**, particularly adjacent the skin incision I. Limiting the amount of instrument grade stainless steel or other difficult to image material of the tissue retractor **200** may not only provides improved line-of-sight for the surgeon, but may also reduce the amount of interference with imaging systems, such as fluoroscopy, when a surgeon images the spinal construct with the tissue retractor **200** mounted to the polyaxial bone screw **100**. Further, reducing the amount of material of the tissue retractor **200** that extends out of the skin incision I generally reduces the size of the skin incision I.

The body **201** is typically constructed of instrument grade stainless steel but may also be constructed of titanium, aluminum, metallic alloys, polymeric materials, composite materials or nearly any relatively stiff, strong, biocompatible material that is able to take on the general shape of the tissue retractor **200** and withstand the normal operating conditions of the tissue retractor **200**. A partial pathway **206** extends longitudinally between the distal and proximal end portions **202**, **204** and is defined by the first and second longitudinally extending edges **224**, **226** and an inner surface **201a** of the body **201**. The partial pathway **206** is nearly completely exposed along a majority of the length of the tissue retractor **200** as a result of the helix-shape of the second longitudinally extending edge **226** such that the tissue retractor **200** functions to retract tissue, as will be described in greater detail below.

The body **201** generally defines a perimeter about the longitudinal tissue retractor axis L-L. The body **201** includes a first portion **220** adjacent the distal end portion **202** and a second portion **222** extending longitudinally from the proximal end portion **204** to the inflection point **217**. A terminal portion **204a** of the proximal end portion **204** has a generally linear and slightly curved cross-section. The body **201** also includes at least one, but typically two, cutout slots **208** extending generally longitudinally along a portion of the body **201** proximate the distal end portion **202**. The two cutout slots **208** are disposed opposite one another proximate the distal end portion **202**. Each cutout slot **208** includes a pair of proximal end portions **208a** and a distal end portion **208b**. A resiliently movable arm **210** is defined by each cutout slot **208**. The arm **210** is movably attached to the body **201** at the proximal end portions **208a** of the cutout slot **208**, by a deflection area **211**, although other configurations for attaching the arm **210** to the body **201** may be utilized, such as a spring-biased hinge or alternate mechanisms that permit the arm **210** to pivot or flex relative to the body **201**. The body **201** also includes a window **230** near the proximal end portion **204** that may be utilized to engage or removably couple the tissue

retractor **200** to various tool and/or instruments, as will be described in greater detail below.

The tissue retractor **200** is removably couplable to the polyaxial bone screw **100** and is rotatably fixed to the polyaxial bone screw **100** when coupled thereto in an assembled configuration (FIG. 5). A portion of the inner surface **201a** of the body **201** receives and contacts a portion of the outer surfaces **110b** of the arms **110** of the body **102** in the assembled configuration, thereby restricting movement of the body **102** of the polyaxial bone screw **100** relative to the tissue retractor **200** in a plane perpendicular to the longitudinal axis L. The tissue retractor **200** also includes at least one and typically four screw engagement ribs **214** (FIGS. 3-5 and 8) extending longitudinally and inwardly toward the longitudinal tissue retractor axis L-L from the distal end portion **202**, generally toward the partial pathway **206**. The body **102** of the polyaxial bone screw **100** includes a corresponding number of complementary collar grooves **118** (FIGS. 1 and 2) extending longitudinally from a proximal end portion **102a** of the body **102**. Each screw engagement rib **214** mates with one of the corresponding collar grooves **118** when the tissue retractor **200** is coupled to the polyaxial bone screw **100** such that the distal end portion **202** surrounds and grasps the arms **110**, thereby restricting rotation of at least the body **102** about the longitudinal axis L. However, when the tissue retractor **200** is mounted to the body **102**, the tissue retractor **200** and body **102** are pivotable and rotatable relative to the bone screw **104**, at least until the body **102** is locked relative to the bone screw **104**, as will be described in greater detail below. Engagement of the screw engagement ribs **214** with the collar grooves **118** provide a relatively bulky thickness, particularly at bulked-up portions **203**, relative to the remainder of the body **201** such that the distal end portion **202** of the tissue retractor **200** and, particularly, the screw engagement ribs **214** are able to react final tightening forces resulting from final tightening of the locking cap **700** to the body **102**, as will be described in greater detail below.

The arm **210** of the tissue retractor **200** includes an attachment tab **212** located adjacent to the distal end portion **208b** of the respective cutout slot **208**, which projects generally transverse to and inwardly toward the longitudinal tissue retractor axis L-L. The arm **210** has a relaxed position (FIGS. 3 and 5), wherein, when the bone anchor assembly **100** and the tissue retractor **200** are in the assembled configuration, the attachment tab **212** is positioned within the recess **116** of the body **102** of the bone anchor assembly **100** (FIG. 5). Longitudinal movement of the body **102** within the partial pathway **206** along the longitudinal tissue retractor axis L is thereby restricted when the tissue retractor **200** is mounted to the body **102**. The arm **210** also has a flexed position (FIG. 4), wherein the arm **210** is deflected outwardly from the tissue retractor **200**, thus spacing the attachment tab **212** from the recess **116** of the bone anchor assembly **100** to permit longitudinal removal of the tissue retractor **200** from the body **102** or to permit the attachment tab **212** to move into the recess **116** without interfering or being blocked by a locking edge **117** of the body **102**.

When the tissue retractor **200** is engaged to the body **102** with the screw engagement ribs **214** positioned within the collar grooves **118**, five degrees of freedom of movement of the tissue retractor **200** are limited relative to the body **102** by the engagement of the engagement ribs **214** with the collar grooves **118**. Specifically, the tissue retractor **200** is generally limited in any rotational movement and any translational movement except for movement away from the body **102** along the longitudinal tissue retractor axis L-L by engagement of the engagement ribs **214** with the collar grooves **118**.

The engagement of the attachment tab **212** with the recess **116** and/or locking edge **117** generally blocks movement of the tissue retractor **200** along the longitudinal tissue retractor axis L-L away from the body **102** and the final potential degree of freedom of movement of the tissue retractor **200** relative to the body **102**. The attachment tab **212** may be sized and configured such that no clamping force is applied by the attachment tab **212** to the sides of the body **102** when the attachment tab **212** is positioned within the recess **116**, as the attachment tab **212** may be configured to block axial movement of the tissue retractor **200** away from the body **102** in the engaged position, as opposed to any additional degrees of freedom. Accordingly, the attachment tab **212** may only block movement of the tissue retractor **200** away from the body through interference between the attachment tab **212** and the locking edge **117** of the recess **116**.

The tissue retractor **200** also generally includes at least one retaining tab **216** proximate the distal end portion **202** of the body **201** that projects from the inner surface **201a** into the partial pathway **206**. The retaining tab **216** is typically positioned on the inner surface of the movable arm **210** proximally or above the attachment tab **212**. However, the retaining tab **216** may be located elsewhere within the partial pathway **206**. When the bone anchor assembly **100** is coupled to the tissue retractor **200**, the proximal end portion **102a** of the body **102** abuts the retaining tab **216** (FIG. 5), thereby preventing further movement of the bone anchor assembly **100** along the longitudinal axis L into the partial pathway **206**.

The tissue retractor **200** also includes at least one, typically the first and second slots **218a**, **218b**, formed at the distal end portion **202** that extend longitudinally from the distal end portion **202** toward the proximal end portion **204**. The first slot **218a** of the exemplary embodiment does not extend the entire length of the tissue retractor **200** and terminates at a closed end portion **219**. When the polyaxial bone screw **100** is coupled to the tissue retractor **200**, the first and second slots **218a**, **218b** are aligned with the rod channel **108** of the body **102**. The second slot **218b** is defined in the first portion **220** of the body **201** by the first and second longitudinally extending edges **224**, **226** of the body **201** that are separated by a first predetermined distance D_1 about the perimeter. In the second portion **222** of the body **201** between the inflection point **217** and the proximal end portion **204**, a distance about an imaginary perimeter between the first and second edges **224**, **226** increases along the longitudinal tissue retractor axis L-L from the first predetermined distance D_1 to a second predetermined distance D_2 at the proximal end portion **204** of the body **201**. The first edge **224** is generally linear and remains at a relatively fixed position on the perimeter along the length of the second portion **222** while the second edge **226** progressively moves farther away in a curvilinear or helix-like manner along the length of the second portion **222** to create the greater distance D_2 at or near the proximal end portion **204**. For example, the tissue retractor **200** shown in FIGS. 3 and 4 exhibits the helical-like cut to the second edge **226**, although other cuts, such as a linear slant, taper, curve, or the like may be used. Further, both the first and second edges **224**, **226** may exhibit the helix-like shape without significantly impacting the function of the tissue retractor **200** of the exemplary instrument set.

Referring to FIGS. 3-5 and 10A-10C, as shown in use, the tissue retractor **200** may reduce the invasiveness of a surgical procedure performed at a motion segment M including a superior and inferior vertebrae V of a patient's spine. For example, in the exemplary embodiment, two tissue retractors **200** having the partial pathways **206** and the helix-like second edge **226** are mounted to polyaxial bone screws **100** and are

angled toward one another into a nested or partially nested configuration (FIGS. 10A-10C), which may reduce the size of the skin incision I. Specifically, the relatively open proximal end portions 204 of the tissue retractors 200 are able to nest at the skin incision I such that a relatively small skin incision I is required. Conventional, enclosed minimally invasive sleeves or cannulae require an incision that accommodates at least twice the diameter of a single sleeve or cannula as the cross-section of these conventional, enclosed minimally invasive sleeves or cannulae form at least a figure eight (8) at the skin incision level. In contrast, the skin incision I required to accommodate the nested tissue retractors 200 may be less than a full diameter of one of the tissue retractors 200, because in the nested configuration the tissue retractors 200 have an mirrored, arcuate-shape or eye-shape (FIG. 10B). In addition, a patient's soft tissue T tends to bias the tissue retractors 200 toward the nested configuration. Further, the tissue retractors 200 may be separated from the nested configuration by the surgeon or utilized in a similar manner to a retractor to spread the skin incision I or move the soft tissue T to change the position of the skin incision I to maximize the surgeon's line-of-site to specific areas of the surgical site or elements of the construct, as long as the bodies 102 remain polyaxially rotatable relative to the bone screws 140.

The tissue retractors 200 typically have a height H_T that is slightly greater than a distance from the implanted polyaxial bone screw 100 at the vertebra V to the skin incision I. Accordingly, the tissue retractor 200 extends only slightly outside of the skin incision I which may provide an increased line-of-sight into a generally conical incision CI for viewing the surgical site and the impacted motion segment M. The tissue retractor 200 is also relatively simple to attach to the polyaxial bone screw 100 utilizing a snap-on action, as was described above, and is a single piece of structure that attaches to the body 102 for use by the surgeon in a similar manner to a retractor blade.

The generally conical incision CI can be made through the patient's soft tissue T to provide access to the motion segment M. The generally conical incision CI is made possible by the nesting of the tissue retractors 200 at their proximal end portions 204 as a result of the helix-like second edges 226. The resulting nesting permits a relatively oblong or eye-shaped single skin incision I (FIGS. 10B and 10C). Further, the tissue retractors 200 are generally sized to extend only a slight amount from the skin incision I to further limit structure and relative clutter in the line-of-sight of the surgeon.

Two bone anchor assemblies 100 can be guided through the generally conical incision CI via a K-wire (not shown) to the superior and inferior vertebrae V, respectively, and are screwed into the vertebrae V. The surgeon may create the conical incision CI by blunt dissection using their finger guided by the Longissimus and Multifidus muscles, which may lead the surgeon to the pedicles of the superior and inferior vertebrae V. Referring specifically to FIGS. 10A-10C, the tissue retractors 200 may also be inserted through the generally conical incision CI at the same time that the bone anchor assemblies 100 are inserted into the generally conical incision CI or may be subsequently coupled to the bone anchor assemblies 100 after mounting the bone anchor assemblies 100 to the vertebrae V. The bone anchor assemblies 100 may be inserted through the conical incision CI with or without the tissue retractors 200 mounted thereto, but the tissue retractors 200 are typically mounted to the bone anchor assemblies 100 during insertion into the generally conical incision CI. The rod R is inserted through the generally conical incision CI as the tissue retractors 200 retract or hold the patient's soft tissue T away from the rod R. The utilization of

the tissue retractors 200 mounted to the polyaxial bone screws 100 permits the surgeon to pivot and rotate the proximal end portions 204 of the tissue retractors 200 into several different orientations and locations to maximize the line-of-sight to the surgical site, as the soft tissue T is somewhat elastic and pliable such that the skin incision I and conical incision CI may be manipulated or otherwise moved by the surgeon. Such manipulation of the incisions I, CI is typically not possible with conventional minimally invasive spine instrumentation wherein tubes, sleeves or cannulae are fixed together in a predetermined arrangement, because the tubes, sleeves or cannulae extending from the polyaxial bone screws are locked together, thereby preventing manipulation of the location, size and/or orientation of the incision or incisions.

The incision utilized for the tissue retractors 200 of a one-level surgery utilizing the exemplary instrument set is typically referred to as a mini-open incision. The exemplary mini-open incision results in the surgeon working through a single, generally conical incision CI with at least two polyaxial bone screws 100 and the spinal rod R included in the construct. The skin incision I of the generally conical incision CI may be utilized to mount one, two or additional level constructs into both lateral pedicles through a single mini-open midline incision by manipulating the incision I, CI over muscle planes on either side of the midline and dissecting to the motion segment M along muscle planes of the soft tissue T.

Referring to FIGS. 16 and 17, when a surgery is performed across at least two motion segments M, first and second tissue retractors 300a, 300b may be mounted to a central bone screw 100. In an assembled configuration, the first and second tissue retractors 300a, 300b define a two-piece tissue retractor 300 that may be used with the central or otherwise interiorly positioned bone screw 100. The first and second tissue retractors 300a, 300b are similar to the one-piece retractor 200 described above. Like numerals have been used for like elements, except the 300 series numerals have been used for the first and second tissue retractors 300a, 300b. Accordingly, a complete description of the individual tissue retractors 300a, 300b has been omitted, with only the differences being described. In the exemplary embodiment, the two-piece tissue retractor 300 includes the first tissue retractor 300a and the second tissue retractor 300b, each of which is removably coupleable to a respective one of the arms 110 of the body 102 of the polyaxial bone screw 100. Each of the first and second tissue retractors 300a, 300b includes a body 301 with a distal end portion 302 and a proximal end portion 304 defining the longitudinal axis L-L and a partial pathway 306 defined between the proximal and distal end portions 302, 304. When coupled to the polyaxial bone screw 100, the first and second tissue retractors 300a, 300b hold back soft tissue T creating a void 307 that permits insertion of the rod R into the patient. The first and second tissue retractors 300a, 300b may be utilized individually with the bone screw 100, but utilizing the pair of the first and second tissue retractors 300a, 300b with the bone screw 100 is utilized to define the void from the incision I to the bone screw 100 to accommodate introduction of the rod R into the bone screw 100.

The first and second tissue retractors 300a, 300b each include an inner surface 301a, a portion of which receives and typically contacts a portion of the outer surface 110b of a respective one of the arms 110, similar to the connection described above with respect to the one-piece tissue retractor 200. The inner surface 301a may have a curvature to define the partial pathway 306. Similarly, each of the first and second tissue retractors 300a, 300b includes a resiliently movable arm 310 defined by a cutout slot 308 of the body 301, screw

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engagement ribs 314, and a retaining tab 316, which function similarly to corresponding portions of the one-piece tissue retractor 200, and will not be described in further detail. When coupled to the polyaxial bone screw 100, the first and second tissue retractors 300a, 300b form at least one rod channel 318 extending longitudinally from the distal end portions 302 to the proximal end portions 304. The rod channel 318 of the assembled first and second tissue retractors 300a, 300b is aligned with the rod channel 108 in the assembled configuration.

Referring to FIGS. 3-6B, 8 and 9, an exemplary cap guide instrument 400 includes a generally cylindrical sleeve 401 having a distal end portion 402, a proximal end portion 404 and a generally cylindrical, hollow cavity 406 extending between the distal and proximal end portions 402, 404 along a longitudinal guide axis G-G. The cap guide 400 is generally constructed of instrument grade stainless steel but may also be constructed of titanium, aluminum, metallic alloys, polymeric materials, composite materials or nearly any relatively stiff, strong, biocompatible material that is able to take on the general shape of the cap guide 400 and withstand the normal operating conditions of the cap guide 400. The cap guide 400 and any of the additional components of the exemplary instrument set may particularly be constructed of Aluminum, an Aluminum alloy or a polymeric material, particularly if improved imaging compatibility is desired.

The cap guide 400 is configured to be removably couplable to the tissue retractor 200 within the partial pathway 206 such that the partial pathway 206 and the hollow cavity 406 are coaxially aligned and the longitudinal tissue retractor axis L-L and the longitudinal guide axis G-G are coaxial (FIG. 8). At least one slot 410 is formed at the distal end portion 402 of the cap guide 400 that extends generally longitudinally along a portion thereof. The slots 410 are defined by arms 422 that extend distally from the sleeve 401. Each arm 422 includes an arched cavity 424 for contacting the rod R (FIG. 19) during insertion of the locking cap 700 and concurrent reduction of the rod R into the rod slot 108 of the body 102. The slot 410 is aligned with one of the resiliently movable arms 210 when the cap guide 400 is coupled to the tissue retractor 200. The cap guide 400 is relatively stiff and strong, particularly when compared to the tissue retractor 200, to react loads encountered by the cap guide 400 when final tightening the locking cap 700 to the body 102. The relatively stiff and strong cap guide 400 is also able to limit damage to other components of the exemplary instrument set, such as the tissue retractor 200, the body 102, the locking cap 700 or any of the other components of the exemplary instrument set during final tightening by reacting the relatively high loads during final tightening. The greatest loads and stresses encountered by the cap guide 400 and the other components of the exemplary instrument set is during final tightening and the cap guide 400 is constructed to withstand this loading condition to protect the other components of the exemplary instrument set, certain of which are designed to maximize a surgeons line-of-sight and subsequently have comparatively lower stiffness and strength. Thus, the cap guide 400 is expected to be present in the incisions I, CI during portions of the procedure when the stiff, strong construction is required to react the final tightening forces rather than during those portions of the procedure when increased visibility is more desirable than increased strength.

The cap guide 400 also includes two indicia 432 at the proximal end portion 404 that are in alignment with the arched cavities 424 at the distal end portion 402. The indicia 432 provide a visual indication to a surgeon for aligning the arched cavities 424 with the rod R while inserting the locking

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cap 700 into the body 102 and the cap guide 400 into the partial pathway 206 to ensure that the arched cavities 424 engage and urge the rod R into the U-shaped rod slot or channel 108 of the body 102. Visually aligning the arched cavities 424 with the rod R during surgery without the indicia 432 could be difficult for a surgeon, because the cap guide 400, the tissue retractor 200 and the patients soft tissue T are typically blocking the surgeons line-of-sight to the surgical site in the minimally invasive procedure. The indicia 432 also assist in aligning a saddle portion 704 of the locking cap 700 with the rod R when the locking cap 700 is engaged with the cap guide 400. A compressor 1100, a distractor 1000, a remover or removal tool 1200, a holder 1300 or other similar instruments that are introduced into the partial pathway 206 may include similar indicia at their proximal end portions to assist a surgeon in properly aligning the instruments with the construct at the surgical site.

The cap guide 400 further includes at least one, and typically four, blocking tabs 408 proximate the distal end portion 402. When coupled to the tissue retractor 200, the blocking tabs 408 are received by at least one, and typically four, blocking ribs 228 of the tissue retractor 200 (FIG. 9). The blocking tabs 408 typically contact inner surfaces 228a of the corresponding blocking ribs 228 in the presence of a force exerted by the bone screw 100 on the inner surface 201a of the tissue retractor 200. The blocking ribs 228 are generally positioned close to the screw engagement ribs 214 in the relatively narrow bulky section at the distal end portion 202 of the tissue retractor 200. Accordingly, any final tightening forces reacted by the tissue retractor 200 flow from the body 102 through the screw engagement ribs 214, through a short or narrow bulked-up portion 203 of the tissue retractor 200 at the distal end portion 202, through the blocking ribs 228 and directly into the strong, stiff cylindrical sleeve 401 of the cap guide 400. Accordingly, the forces of final tightening are essentially shielded from the relatively thin tissue retractor 200 by immediately directing the forces into the cap guide 400 by transferring the forces through the short bulked upon portion 203 of the tissue retractor 200 at the distal end portion 202. The cap guide 400 therefore limits splay of the body 102 of the polyaxial bone screw 100 and the tissue retractor 200 during insertion of the locking cap 700.

A gap may be defined between the blocking tabs 408 and the inner surfaces 228a of the corresponding blocking ribs 228 (FIG. 9) to accommodate sliding insertion of the cap guide 400 into the tissue retractor 200 by providing clearance for insertion of the blocking tabs 408 into the gap between the blocking ribs 228 and the body 201 of the tissue retractor 200. The gap is relatively small to limit splay of the tissue retractor 200 and the body 102 when the assembly is subjected to final tightening forces.

A guide button 426 extends radially outwardly from a side of the cylindrical sleeve 401 proximate the distal end portion 402. The guide button 426 has a button width W_B that is slightly smaller than a slot width W_S (FIG. 4) of the second slot 218b. The guide button 426 also includes relatively smooth, arcuate corners 428, particularly on a distal end portion. When inserting the cap guide 400 into the partial pathway 206 of the tissue retractor 200, the guide button 426 self-guides and orients the cap guide 400 into proper alignment with the tissue retractor 200. For example, if the cap guide 400 is introduced into the partial pathway such that the guide button 424 initially contacts the second longitudinal, helix-shaped edge 226, the guide button 424 slides down the second helix-shaped edge 226 until the guide button 426 drops into the second slot 218b. When the guide button 426 is positioned in the second slot 218b in the assembled configura-

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ration, the arched cavities **424** and the indicias **432** are aligned with the rod **R** and the blocking tabs **408** are positioned between the blocking ribs **228** and the body **201**, generally at four locations, to limit splay of the tissue retractor **200** and the body **102**. In addition, the guide button **426**, the arms **422** and the blocking tabs **408** may cooperate to secure the cap guide **400** relative to the tissue retractor **200** in five of six degrees of freedom, with the exception being the movement of the cap guide **400** out of the partial pathway **206** along the longitudinal tissue retractor axis **L-L'** away from the distal end portion **202** of the tissue retractor **200**.

Anti-splay wings **440** extend radially outwardly from the sleeve **401** near the proximal end portion **404** and define a capture groove **442** between the sleeve **401** and a distal wing end portion **440a**. In the assembled configuration, when the cap guide **400** is positioned in the partial pathway **206** with the blocking tabs **408** located between the blocking ribs **228** and the body **201**, the terminal portion **204a** at the proximal end portion **204** of the tissue retractor **200** is positioned within the capture groove **442** to limit outward splay of the proximal end portion **204** during use. The two anti-splay wings **440** may be utilized, for example, with the two-piece retractor **300** to engage the proximal end portions of the first and second tissue retractors **300a**, **300b**, respectively.

The cap guide **400** also typically includes clearance windows **450** and capture grooves **460** on either side near the proximal end portion **404**. The clearance windows **450** and the capture grooves **460** are utilized with additional instruments of the exemplary instrument set to manipulate or align the cap guide **400** with other instruments, which will be described in greater detail below.

Referring to FIGS. **8** and **11**, a screwdriver **500** may be utilized with the polyaxial bone screw **100**, tissue retractor **200** and cap guide **400** assembly for threadably securing the locking cap **700** (FIG. **12**) onto the body **102** of the polyaxial bone screw **100**. The screwdriver **500** includes a handle **502** and a drive shaft **504** extending therefrom. The drive shaft **504** has a diameter that is less than a diameter of the hollow cavity **406** within the cap guide **400**. Accordingly, the drive shaft **504** is rotatable with respect to the cap guide **400** when positioned therein. The drive shaft **504** has a terminal end portion (not shown) which is configured to mate with a drive feature **701** on top of the locking cap **700** in a releasable, rotatably fixed fashion.

Referring to FIGS. **6A-8**, a counter-torque handle **600** has a gripping end portion **602** and an interlock end portion **604**. The interlock end portion **604** includes an instrument interface **606** that is releasably positionable within the hollow cavity **406** at the proximal end portion **404** (FIG. **6B**). When inserted into the hollow cavity **406**, the instrument interface **606**, and consequently the counter-torque handle **600**, are rotatably fixed with respect to the cap guide **400**. The instrument interface **606** includes a generally smooth inner surface **606a** and at least one spline **606b** on an external surface that mates with a complementary spline **412** in the hollow cavity **406** at the proximal end portion **404** of the cap guide **400**. The at least one spline **606b** and the complementary spline **412** may be comprised of an octagonal spline or a spline having eight sides that are configured to align the gripping end portion **602** with the indicias **432** and the rod **R**, are positioned perpendicular to the indicias **432** and the rod or are oriented at forty-five degrees (45°) relative to the indicias **432** and the rod **R**. Accordingly, the surgeon may orient the gripping end portion **602** generally perpendicular to the surgeon, generally pointing away from the surgeon, generally pointing toward the surgeon or oriented at forty-five degrees (45°) toward and/or away from the surgeon. Such orientations permit the

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counter-torque handle **600** to be adaptable to left and right handed surgeons, to grasping by assistants and/or generally for surgeon comfort. The surgeon may utilize these various orientations for comfort or for an assistant to hold the counter-torque handle **600**. The spline **606b** and complementary spline **412** may also be configured to have nearly any number of sides that are divisible by four (**4**), for example, square splines such that the surgeon has at least four orientations to position the counter-torque handle **600** relative to the cap guide **400** or other instrument.

The interlock end portion **604** further includes an open-ended slot **610** having a width greater than the diameter of the drive shaft **504**. The drive shaft **504** is therefore not only rotatable within the open-ended slot **610** of the counter-torque handle **600**, but the counter-torque handle **600** is insertable and removable from the cap guide **400** while the drive shaft **504** is within the hollow cavity **406** of the cap guide **400** and while the cap guide **400** is within the partial pathway **206** of the tissue retractor **200**. Accordingly, insertion, tightening, and counter-torque operations of the locking cap **700** can be performed without excessive removal and replacement of instruments and the counter-torque handle **600** can be engaged with the cap guide **400** when it is required for final tightening. In addition, the solid engagement provided between the counter-torque handle **600** and the body **102** of the polyaxial pedicle screw **100** is relatively stiff and strong because of the arrangement of the tissue retractor **200** and the cap guide **400** and their engagement with each other and the body **102**. Specifically, final tightening loads are generally shielded from the tissue retractor **200**, except at the bulked-up portion **203** between the screw engagement ribs **214** and the blocking ribs **228** at the distal end portion **202** where the tissue retractor **200** includes extra strength and stiffness to react the load. Accordingly, the instrumentation necessary for final tightening, including the tissue retractor **200**, the cap guide **400** and the counter-torque handle **600**, is positioned at least near the generally conical incision **CI** during the final tightening procedure and may be quickly removed and adapted during alternate steps of the procedure. The cap guide **400** is not specifically necessary for final tightening of the construct, as final tightening may also be performed with the distractor **1000**, the compressor **1100**, a threaded persuader **1500** or other related instrument that engages the body **102**, receives the screwdriver **500** and counter-torque handle **600** and is able to retain the locking cap **700**.

The instrument interface **606** may also be configured such that the at least one spline **606b** is defined in the inner surface **606a** for grasping the complementary spline **412** on the external surface of the cap guide **400** (not shown). Such a configuration permits the open-ended slot **610** to accommodate quick engagement and release of the counter-torque handle **600** with the cap guide **400** without removal of the screwdriver **500** or other instruments from the incision **I**.

Referring now to FIG. **11**, the locking cap **700** is typically constructed of titanium or a titanium alloy, such as an alloy including Titanium, Aluminum and Niobium (TAN—Ti-6Al-6Nb—ASTM F 1295) but may also be constructed of stainless steel, other metallic alloy materials or nearly any strong, stiff, biocompatible material that is able to take on the general size and shape of the locking cap **700** and withstand the normal operating conditions of the locking cap **700**. The locking cap **700** includes a threaded portion **702** and the saddle **704** rotatably mounted to the threaded portion **702**. The saddle **704** is generally machined with a post (not shown) that mates with an axial hole (not shown) in the threaded portion **702** and is rotatably secured thereto. The locking cap

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700 is generally shown in WO 100 and is not limited to constructions including the saddle 704 and the threaded portion 702. For example, the locking cap 700 may be comprised of nearly any style or variety of locking cap that is known to those having ordinary skill in the art. The threaded portion 702 includes a plurality of threads 712 that mate with the threaded portions 114 of the inner surfaces 110a of the arms 110 of the body 102 in the polyaxial bone screw 100. The saddle portion 704 includes two downwardly extending arms 706, 708 that form an arched cavity 710 therebetween. The saddle 704 includes a grooved surface 704a that assists in securing the saddle 704 to the rod R in the implanted and locked position. The cavity 710 is sized and shaped to complementarily receive the rod R when the locking cap 700 is mounted in the polyaxial bone screw 100.

Referring to FIGS. 6A, 6B, 11 and 18, the locking cap 700 is removably insertable into a distal end portion of the hollow cavity 406 of the cap guide 400 and the saddle 704 is rotatable with respect to the cap guide 400 and the threaded portion 702 when the locking cap 700 is secured to the cap guide 700. To accommodate the locking cap 700, the exemplary cap guide 400 includes a movable cap tab 414 (FIG. 18), located proximate the distal end portion 402 of the cap guide 400 and projecting into the hollow cavity 406. The cap tab 414 is disposed at a distal end portion 418 of a resiliently movable arm 416 of the cap guide 400 (FIG. 6). The movable arm 416 is attached at a proximal end portion 420 thereof to the sleeve 401 of the cap guide 400. The cap tab 414 may alternatively be comprised of a portion of thread (not shown) that projects into the hollow cavity 406 to engage the threaded portion 702 of the locking cap 700 and secure the locking cap 700 to the distal end portion 402 of the cap guide 400. Further, the cap guide 400 may include additional alternative mechanisms to temporarily secure the locking cap 700 in the hollow cavity 406 of the cap guide 400, such as hook and loop material, adhesive materials, clamps, releasable fasteners or like mechanisms.

In the exemplary embodiment, the movable arm 416 is constructed of a spring steel material and is welded at a proximal peripheral edge 416a to the cap guide 400. A gap 416b is defined between the movable arm 416 and the cap guide 400 at a distal periphery of the movable arm 416 such that the distal end portion 418 of the movable arm 416 may flex to receive and release the locking cap 700 during insertion and removal of the locking cap 700, respectively, from the hollow cavity 406. The locking cap 700 is prevented from being over-inserted into the hollow cavity 406 by a narrowed portion 409 (FIG. 18) of the cap guide 400 that extends radially inwardly into the hollow cavity 406 proximate the distal end portion 402 and abuts a top surface 702a of the locking cap 700 to align a longitudinal cap axis C-C with the longitudinal guide axis G-G of the cap guide 400. The cap tab 414 is received in threads 712 of the threaded portion 702 of the locking cap 700 when the locking cap 700 is inserted and secured in the hollow cavity 406 of the cap guide 400 in the assembled configuration.

With the locking cap 700 in the hollow cavity 406 of the cap guide 400, the cap guide 400 is positioned within the tissue retractor 200 such that the partial pathway 206 and the hollow cavity 406 are coaxially aligned and the locking cap 700 is coaxially aligned with the body 102 of the polyaxial bone screw 100. In this assembled configuration, the longitudinal cap axis C-C is generally coaxial with the longitudinal tissue retractor axis L-L and the longitudinal guide axis G-G. This configuration permits mating of the threaded portion 702 of the locking cap 700 with the threaded portions 114 of the body 102 without cross-threading or the like because the

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alignment of the cap guide 400 and cap screw 700 automatically provides vertical alignment of the threaded portion 702 of the locking cap 700 with the threaded portions 114 of the body 102 when the cap guide 400 is properly locked in position within the tissue retractor 200 (FIG. 8). The drive shaft 504 of the screw driver 504 is also preferably coaxially aligned with the longitudinal tissue retractor axis L-L, the longitudinal guide axis G-G and the longitudinal cap axis C-C in this assembled configuration (FIG. 8).

Referring to FIGS. 6A, 6B, 8 and 12-14, other instruments such as the compressor 1100, the distractor 1000, the removal tool 1200, the holder 1300 or the like may be used in conjunction with the exemplary instrument set that also limit splay, cross-threading, and other unfavorable consequences of insertion and final tightening of the locking cap 700 to lock the rod R in the polyaxial bone screw assembly 100 and the bone screw 104 relative to the body 102. For example, the compressor 1100 and/or the distractor 1000 have many similar structural features to that of the cap guide 400, particularly at their distal end portions to engage the tissue retractor 200 and the locking cap 700. Accordingly, like numerals have been used for like elements, except the 1000 series numerals have been used to identify features of the distractor 1000 and 1100 series numerals have been used to identify features of the compressor 1100. Accordingly, a complete description of the exemplary embodiment of the compressor 1100 and the distractor 1000 have been omitted, with only the notable differences being described. The compressor 1100 and the distractor 1000 include many of the features of the cap guide 400 while retaining their specific features that permit distraction and compression between adjacent polyaxial bone screws 100, which are apparent to those having ordinary skill in the art, for the function of the compressor 1100 and the distractor 1000. Accordingly, although the cap guide instrument 400 is described in this application for performing a number of functions during spine surgery, the compressor 1100 and the distractor 1000 or other similar instruments may be substituted therefore, when appropriate.

Referring to FIGS. 12-14, the distractor 1000 and the compressor 1100 both include a ratchet arm 1017, 1117, a pivoting arm 1019, 1119 that is pivotally mounted to the cylindrical sleeve 1001, 1101 and a ratchet mechanism 1021, 1121 that can be used to lock the pivoting arm 1019, 1119 relative to the cylindrical sleeve 1001, 1101 or mechanically move the pivoting arm 1019, 1119 relative to the cylindrical sleeve 1001, 1101. The distractor 1001 includes a blunt end portion 1019a at the distal end portion of the pivoting arm 1019 and the compressor 1100 includes a hooked end portion 1119a at the distal end portion of its pivoting end 1119. In use, the blunt end 1019a of the distractor 1000 abuts a side surface of the locking cap 700 of an adjacent polyaxial screw 100 while the cylindrical sleeve 1001 is secured to the other polyaxial screw 100 and the screws 100 are urged away from each other, typically to relief pressure on nerves between two adjacent vertebrae V. In contrast, the hooked end portion 1119a of the compressor 1100 extends through the first and second slots 218a, 218b of the tissue retractor 200 opposite the screw 100 that the cylindrical sleeve 1101 is attached to. The hooked end 1119a engages the locking cap 700 of this screw 100 and urges the polyaxial screws 100 and adjacent vertebrae V toward each other to compress the vertebrae V together or against a spacer S (FIG. 10C) positioned between the vertebrae V.

Referring to FIGS. 3-6B, 8 and 19A, the exemplary instrument set of the present application includes a scissor persuader 1400 having groove engaging arms 1402 attached to a first hand grip 1460a, a window engaging nose 1404 secured

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to a second hand grip **1460b** and a release tab **1406**. When a polyaxial screw **100** has been inserted into the vertebrae V with the tissue retractor **200** mounted thereto, the rod R is positioned in the rod slot **108** and the cap guide **400** with the locking cap **700** secured at the distal end portion **402** of the cap guide **400** is positioned in the partial pathway **206**, the rod R may be difficult to fully seat in the rod saddle **101a** in certain situations. In addition, it may be difficult for the surgeon to urge the rod R far enough into the rod slot **108** to initially engage the threads **712** of the threaded portion **702** with the threaded portions **114** of the arms **110** with only hand or manual force. The scissor persuader **1400** may be utilized to apply mechanical force to urge the cap guide **400** downwardly within the partial pathway **206** of the tissue retractor **200** to urge the rod R into the rod slot **108** and/or the threads **712** of the threaded portion **702** into engagement with the threaded portions **114** of the arms **110**.

In use, the groove engaging arms **1402** are positioned in the grasping grooves **460** and the window engaging nose **1404** is engaged with a proximal end of the window **230** of the tissue retractor **200**. The first and second handle grips **1460a**, **1460b** are squeezed together to urge the groove engaging arms **1402** toward the window engaging nose **1404** and the cap guide **400** further into the partial pathway **206** of the tissue retractor **200**. Urging the cap guide **400** downwardly causes the locking cap **700** to urge the rod R downwardly into the rod slot **108**. The scissor persuader **1400** may be utilized without blocking insertion of the drive shaft **504** of the screwdriver **500** into the hollow cavity **406** and into engagement with the drive feature **701** of the locking cap **700**. In addition, the scissor persuader **1400** does not block engagement of the counter-torque handle **600** with the cap guide **400**. When the cap guide **400** has been persuaded to the assembled or working configuration relative to the tissue retractor **200**, the persuader **1400** locks in position such that the surgeon does not have to continue to hold the first and second hand grips **1460a**, **1460b** to maintain the position of the cap guide **400** relative to the tissue retractor **200**. To release the lock of the scissor persuader **1400**, the release tab **1406** is actuated and the scissor persuader **1400** may be removed from engagement with the cap guide **400** and the tissue retractor **200**. The position of the clearance window **450** in alignment with the window **230** of the tissue retractor **200** provides clearance for the window engaging nose **1404** in operation.

Referring to FIGS. 1-8 and 19B, a threaded persuader **1500** may be utilized to similarly persuade the rod R into the rod slot **108**, typically in situations where the travel of the scissor persuader **1400** is insufficient to persuade the rod R. The threaded persuader **1500** includes spring arms **1502** on opposing sides, a slider **1504** that releasably engages the locking cap **700** in a similar manner to the above-described cap guide **400**, a hand actuator **1506** at a proximal end of the threaded persuader **1500** to move the slider **1504** relative to the cylindrical sleeve **1501**, anti-splay wings **1540** and an internal spline **1508** to engage the spline **606b** of the counter-torque handle **600**.

In use, if the rod R is positioned proud of the rod slot **108** a sufficient distance that the scissor persuader **1400** is unable to engage the cap guide **400** and the tissue retractor **200** to persuade the rod R or the scissor persuader **1400** is unable to apply enough force to persuade the rod R, the threaded persuader **1500** may be introduced into the partial pathway **206** and engage the tissue retractor **200** proximate the distal end portion **202** in a similar manner to the cap guide **400**. When fully assembled and seated in the tissue retractor **200**, the spring arms **1502** spring outwardly into the windows **230** or a single window **230** of the tissue retractor **200** to translatably

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secure the threaded persuader **1500** relative to the tissue retractor **200** and the polyaxial screw **100** along the longitudinal tissue retractor axis L-L. The hand actuator **1506** is rotated relative to the cylindrical sleeve **1501** such that the slider **1504** moves downwardly toward the distal end and the saddle **704** engages the rod R. Further pivoting of the hand actuator **1506** urges the slider **1504** further toward the distal end and persuades the rod R into the rod slot **108** and the threads **712** of the threaded portion **702** into engagement with the threaded portions **114** of the arms **110**. The urging forces of pushing the rod R into the rod slot **108** are reacted through the tissue retractor **200** and into the cylindrical sleeve **1501** through the spring arms **1502**. When the rod R is persuaded a sufficient amount to allow engagement of the threads **712** of threaded portion **702** with the threaded portions **114** of the arms **110**, the drive shaft **504** of the screwdriver **500** is introduced through the hollow central channel **1510** of the threaded persuader **1500** to screw the locking cap **700** into the body **102**. To remove the threaded persuader **1500** from the tissue retractor **200**, the spring arms **1502** are urged inwardly out of the window **230** and the threaded persuader **1500** slides out of the partial pathway **206**.

Referring to FIGS. 1-5, 10A-10C, 13, 14, 16, 17 and 20, to remove the tissue retractors **200**, **300** from the polyaxial bone screw **100** or any other mechanism that engages the polyaxial bone screw **100** with a device similar to the resilient movable arms **210** of the tissue retractors **200**, **300**, the removal tool **1200** is utilized to actuate the resiliently movable arms **210** from the relaxed position to the flexed position. The removal tool **1200** includes a cylindrical sleeve **1201**, spring arms **1202**, actuating arms **1204** with ramped distal surfaces **1206**, a handle **1208** and anti-splay wings **1240**.

In use, after the polyaxial screws **100** are inserted in the vertebra V, the locking caps **700** have been final tightened and the cap guide **400**, counter torque handle **600**, screwdriver **500** and other components have been removed from the partial pathway **206**, the removal tool **1200** is inserted into the partial pathway **206**. The cylindrical sleeve **1201** has a diameter slightly smaller than an inner diameter of the tissue retractor **200** proximate the distal end portion **202**. The cylindrical sleeve **1201** slides into the partial pathway **206** until one of the spring arms **1202** snap into the window **230**, the window **330** or a related feature on other instruments of the exemplary instrument set to axially secure the removal tool **1200** to the tissue retractors **200**, **300**. In this position, the actuating arms **1204** engage the retaining tab **216**, **316** to urge the resiliently movable arms **210**, **310** to the flexed position, wherein the attachment tab **212**, **312** is moved out of engagement with the recess **116** on the body **102**. The ramped distal surfaces **1206** facilitate the flexing of the resilient movable arms **210**, **310** outwardly to the flexed position. The anti-splay wings **1240**, particularly with the first and second tissue retractors **300a**, **300b**, laterally retain the tissue retractors **200**, **300** relative to the cylindrical sleeve **1201**. The removal tool **1200** and the tissue retractor **200**, **300** or related instruments may then be removed from the patients body out of the generally conical incision CI and through the skin incision I.

The spring arms **1202** typically include a ramped nose **1202a** and a relatively squared or blunt butt end portion **1202b**. The ramped nose **1202** facilitates engagement of at least one of the springs arms **1202** in the window **230** of the tissue retractor **200** as the cylindrical sleeve **1201** of the removal tool **1200** slides into the partial pathway **206**. The blunt butt end portion **1202b** is generally positioned against or near a proximal end of the window **230** to inhibit sliding movement of the removal tool **1200** out of the partial pathway **206** once the spring arm **1202** is engaged with the window

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230. The spring arms 1202 operate in a similar manner with respect to the windows 330 of the first and second tissue retractors 300a.

The windows 230, 330 may include a rough or uneven surface 230a, 330a proximate the windows 230, 330 on an outer surface of the bodies 201, 301. The rough or uneven surface 230a, 330a proximate the windows 230, 330 facilitate gripping and handling of the tissue retractors 200, 300 by surgeons and technicians in an operating environment. For example, the rough or uneven surface 230a, 330a permits a surgeon, who may have wet and slimy gloves on their hands, to grip the rough or uneven surface 230a, 330a with a thumb while urging the spring arm 1202 out of the window 230, 330 and sliding the removal tool 1200 out of the partial pathway 206, 306 of the tissue retractor 200, 300. The surgeon's wet and slimy finger may slip on the outer surface of the bodies 201, 301 without inclusion of the rough or uneven surface 230a, 330a. The rough or uneven surface 230a, 330a may be comprised of grooves, knurling, cavities, spikes, surface roughenings or other like features.

Referring to FIGS. 1-5, 16, 17, 21A and 21B, a holder 1300 is utilized to hold the polyaxial screw 100 and tissue retractors 200, 300 to drive the polyaxial screws 100 into the vertebrae V. The holder 1300 includes a cylindrical sleeve 1301, a hollow retaining shaft 1302 with a threaded distal end portion 1302a, a holding sleeve 1304 at a proximal end and a safety shield 1306 that is slidable along an outside of the holding sleeve 1304. The holding sleeve 1304 includes an anti-splay ring 1340 at its distal end to laterally retain the tissue retractors 200, 300 in an assembled configuration. The safety shield 1306 includes several spring arms 1306a that are selectively engageable with a first groove 1304a in an actuating position (FIG. 21B) and a second groove (not shown) in a safety position (FIG. 21A) on the external surface of the holding sleeve 1304. The holding sleeve 1304 also includes an actuating window 1304c that exposes an actuator 1302a on an external surface of the retaining shaft 1302.

In use, the safety shield 1306 is moved to an actuating position wherein the spring arms 1306a engage the first groove 1304a to secure the safety shield 1306 in the actuating position. The threaded end portion 1302a of the retaining shaft 1302 is engaged with the internal threaded portion 114 of the arms 110 by manipulating the actuator 1302a through the actuating window 1304c, which is exposed when the safety shield 1306 is in the actuating position. The tissue retractors 200, 300 are attached to the holder 1300 such that the proximal end portion 204 is positioned under the anti-splay ring 1340. The polyaxial screw 100 and the holder 1300 are guided to the surgical site through the generally conical incision CI by a K-wire (not shown). When a tip of the bone screw 104 contacts the vertebra V, the screwdriver 500 may be inserted down the hollow retaining shaft 1302 to drive the polyaxial screw 100 into the vertebra V. When the screwdriver 500 is driving the screw 104 into the vertebra V, the safety shield 1306 is moved to the safety position covering the actuating window 1304c and the actuator 1302a to prevent a surgeon from moving the actuator 1302a and disengaging the retaining shaft 1302 from the polyaxial pedicle screw 100. The surgeon grasps the holder 1300 at the safety shield 1306 and the holding sleeve 1304 and drive the polyaxial screw 100 into the vertebra V. The safety shield 1306 is then moved from the safety position to the actuating position, where the spring arms 1306a engage the first groove 1304a to retain the safety shield 1306 in the safety position. The actuator 1302a is manipulated to rotate the retaining shaft 1302 and disengage the distal threads 1302a from the internal threaded portions 114 of the arms 110. The holder 1300 is removed from the

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generally conical incision CI leaving the polyaxial screw 100 and tissue retractors 200, 300 in the generally cylindrical incision CI.

Referring to FIGS. 6A, 6B, 12 and 22, the exemplary instrument set also includes a cap tray 1600 for storage and staging of the locking caps 700. The cap tray 1600 of the exemplary embodiment includes six cap stations 1602 that each receive an individual locking cap 700. The cap tray 1600 is not limited to the inclusion of six cap stations 1602 and may include nearly any number of cap stations 1602 that is desired by the use for storing a desired number of locking caps 700. Each of the cap stations 1602 includes a centrally located pedestal 1604 with an arcuate top surface that mates with the actuate surface 704a of the saddle portion 704, four alignment ribs 1606 and two button grooves 1608. The alignment ribs 1606 cooperate with the blocking tabs 408 and the arm 422 to align the arms 706, 708 of the saddle 704 generally perpendicular to the indicia 432 such that the saddle 704 is aligned to engage the rod R when the cap guide 400 is positioned in the partial pathway 206. The button groove 1608 receives the guide button 426 of the cap guide 400 to ensure alignment of the saddle 704 with the cap guide 400 for receipt of the rod R.

In use, the cap guide 400 or any other instrument of the exemplary instrument set, including the distractor 1000 or compressor 1101 that receive and retain the locking caps 700 therein, may stab and grab the locking caps 700 directly from the cap tray 1600. Specifically, the user grasp the cap guide 400 and stabs the locking cap 700 that is positioned in one of the cap stations 1602. The features at the distal end of the cap guide 400 cooperate with the features in the individual cap station 1602 to align and properly position the locking caps 700 at the distal end portion 402 of the cap guide 400. The cap tab 414 engages the threads 712 of the locking cap 700 to coaxially align the locking cap 700 with the hollow cavity 406. Therefore, when the cap guide 400 with a locking cap 700 secured in the distal end is introduced into the partial pathway 206 and the saddle 704 engages the rod R, the saddle 704 is pre-oriented to engage the rod R and the threads 712 are pre-oriented to engage the threaded portions 114 of the arms 110. Such a configuration may ease insertion of the locking cap 700 onto the body 102 and diminishes any possibility that the threads 712 of the locking cap 700 cross-thread with the threaded portions 114 of the arms 110, due to the pre-orientation of the locking cap 700 relative to the body 102.

Referring to FIGS. 1-22, in use, the polyaxial bone screw 100 is coupled to the tissue retractor 200 by sliding the distal end portion 202 of the tissue retractor 200 over the body 102 until the attachment tabs 212 mate with the corresponding recesses 116 of the body 102. Lower or distal surfaces of the attachment tabs 212 are tapered in a ramp-like configuration such that the top edge of the arms 110 urge the attachment tabs 212 from the relaxed position to the flexed position to allow the attachment tabs 212 to move over and past the locking edge 117 into the recesses 116. The polyaxial bone screw 100 is fixed to a vertebra V of a patient (FIG. 21), typically guided by the K-wire. The polyaxial pedicle screws 100 and the tissue retractors 200, 300 are inserted into the generally conical incision CI using the holder 1300, as was described above. Adjacent tissue retractors 200 move to the nested configuration (FIG. 10B) under the urging of the surgeon and the patient's soft tissue T. A portion of the rod R is inserted through the tissue retractor 200 until the rod R is seated in the rod receiving portion 112 of the polyaxial bone screw 100.

The locking cap 700 is positioned within one of the cap stations 1602 of the cap tray 1600 such that the saddle portion 704 is in an aligned configuration with respect to the tray 1600. The distal end portion 402 of the cap guide 400 is

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placed over the locking cap 700 in the tray 1600 to receive the locking cap 700. By virtue of the locking cap 700 having been previously aligned within the tray 1600, the saddle portion 704 of the locking cap 700 is aligned within the cap guide 400 when the cap guide 400 receives the locking cap 700 from the tray 800. That is, the arms 706, 708 of the locking cap 700 align with the slots 410 in the cap guide 400. The locking cap 700 is inserted through the tissue retractor 200 using the cap guide 400 until the cavity 710 in the saddle portion 704 of the locking cap 700 mates with the rod R and the threaded portion 702 thereof is received by the threaded portions 114 of the body 102 of the polyaxial bone screw 100.

As is described above, the locking cap 700 is aligned with and positioned for engagement within the partial pathway 206 of the tissue retractor 200 without ever coming into contact with the screwdriver 500. Although the screwdriver 500 generally includes a self-retaining feature when engaged to the locking cap 700, such a feature is typically less stable than the above-described engagement between the locking cap 700 and the cap guide 400. Specifically, when the cap guide 400 is moving downwardly through the partial pathway 206, the locking cap 700 is generally surrounded and protected from disengagement forces by the distal end portion 402 of the cap guide 400. Therefore, risk of the locking cap 700 disengaging from the cap guide 400 during insertion through the partial pathways 206 of the tissue retractors 200 in the assembled and implanted positions is less likely than situations where the locking cap 700 is self-retained by the screwdriver 500, inserted through the generally conical incision CI and into engagement with the body 102. Disengagement of the locking cap 700 from any instrument while in the conical incision CI is unfavorable as the locking cap 700 must be retrieved through the minimally invasive, generally conical incision CI. The engagement of the locking cap 700 with the distractor 1000, the compressor 1100, the threaded persuader 1500 or other similar instruments provides similar retaining protections to the locking cap 700.

Generally, concurrently with the locking cap 700 being received by the body 102, the cap guide 400 is coupled to the tissue retractor 200 to rotatably fix the tissue retractor 200 to the cap guide 400 by mating the blocking ribs 228 of the tissue retractor 200 with the corresponding blocking tabs 408 of the cap guide 400. The drive shaft 504 is then inserted into the hollow cavity 406 of the cap guide 400 to mate with the locking cap 700. The surgeon can now perform initial tightening of the locking cap 700 within the body 102 to at least provisionally secure the rod R to the polyaxial screw assembly 100.

Once the locking cap 700 is provisionally tightened, any manipulation of the position of the polyaxial bone screw 100 with respect to the rod R, such as compression or distraction with another polyaxial bone screw 100, can be performed without removing the drive shaft 504 from the hollow cavity 406 of the cap guide 400, assuming the locking cap 700 is inserted utilizing the distractor 1000 or compressor 1100, respectively. The counter-torque handle 600 is coupled to the cap guide 400 by inserting the drive shaft 504 into the open-ended slot 610 of the counter-torque handle 600 and inserting the instrument interface 606 into the hollow cavity 406 of the cap guide 400, typically by mating the splines 608b of the counter-torque handle 600 with the complementary splines 412 of the cap guide 400. In this configuration, the drive shaft 504 is rotatable within the counter-torque handle 600. Final tightening of the locking cap 700 is performed, such that the locking cap 700 bears against the rod R, by rotating the drive shaft 504. The rod R is thereafter fixed with respect to the polyaxial bone screw 100 and the torque input to the polyaxial

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pedicle screw assembly 100 by the screwdriver 500 is reacted through the body 102, the bulked-up portion 203 of the tissue retractor 200 between the blocking ribs 228 and the screw engagement ribs 214, the stiff and strong sleeve 401 of the cap guide 400 and the counter-torque handle 600. Accordingly, the relatively thin body 201 of the tissue retractor 200 and the arms 110 do not react significant portions of the final tightening forces and only react the forces over short distances adjacent the top end of the arms 110.

It will be appreciated by those skilled in the art that changes could be made to the exemplary embodiment described above without departing from the broad concept thereof. It is understood, therefore, that the described device and method are not limited to the particular embodiment disclosed, but it are intended to cover modifications within the spirit and scope of the exemplary embodiment as defined by the appended claims.

What is claimed:

1. A method of attaching a locking cap to a bone anchor assembly that includes a bone anchor body and an elongate rod positioned in a channel defined by the bone anchor body, the method comprising the steps of:

inserting a locking cap down a pathway defined by a tissue retractor to the bone anchor body, wherein the tissue retractor is supported by the bone anchor body and the inserting comprises inserting a cap guide into the pathway such that a cavity of the cap guide is coaxial with the pathway, the locking cap being coupled to a distal end of the cap guide;

inserting a screwdriver into the cavity such that a distal end of the screwdriver is adjacent the locking cap;

decoupling the locking cap from the distal end of the cap guide with the screwdriver such that the locking cap seats within the channel;

coupling the locking cap to the bone anchor body so as to affix the elongate rod to the bone anchor;

inserting a removal tool into the pathway so as to 1) couple the removal tool to the tissue retractor at a first location so as to axially secure the removal tool to the tissue retractor at the first location and 2) decouple the tissue retractor from the bone anchor body at a second location spaced from the first location; and

moving the removal tool away from the bone anchor body so as to remove the tissue retractor coupled to the removal tool from the bone anchor body.

2. The method of claim 1, wherein prior to the first inserting step, coupling the tissue retractor to the bone anchor body; and attaching the bone anchor body to a vertebra after the tissue retractor is coupled to the bone anchor body.

3. The method of claim 1, wherein the step of inserting the cap guide comprises the step of:

causing at least two blocking tabs that extend from the distal end of the cap guide to be received by at least two blocking ribs that extend from the tissue retractor and into the partial pathway.

4. The method of claim 3, further comprising the steps of: rotatably fixing a counter torque handle to the cap guide while the screwdriver is inserted into the cavity; and applying a torque to the locking cap with the screwdriver.

5. The method of claim 4, wherein the counter torque handle includes an interlock end portion that defines an instrument interface and an open ended slot, and wherein the step of rotatably fixing the counter torque handle comprises the steps of:

receiving the screwdriver within the open ended slot along a first direction such that the screwdriver is rotatable within the slot; and

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translating the counter torque handle along the screwdriver along a second direction that is perpendicular to the first direction such that the instrument interface is received within the cavity of the cap guide.

6. The method of claim 5, wherein the cavity defines at least one spline and the instrument interface defines at least one spline, and wherein the translating step comprises:

5 mating the at least one spline of the instrument interface with the at least one spline of the cavity.

7. The method of claim 1, further comprising the step of: 10 coupling the locking cap to the cap guide by stabbing and grabbing the locking cap from a cap tray.

8. The method of claim 7, wherein the step of stabbing and grabbing the locking cap comprises:

15 mating a feature on the cap guide with a complimentary feature defined by the cap tray to thereby align the cap guide with the locking cap.

9. The method of claim 1, wherein the step of decoupling the locking cap from the distal end of the cap guide comprises:

20 applying an axial force to the locking cap with the screwdriver such that the axial force decouples the locking cap from the distal end of the cap guide.

10. A method of attaching a locking cap to a bone anchor assembly that includes a bone anchor body and an elongate rod positioned in a channel defined by the bone anchor body, the method comprising the steps of:

25 inserting a locking cap down a pathway defined by a tissue retractor to the bone anchor body, wherein the tissue retractor is supported by the bone anchor body;

30 coupling the locking cap to the bone anchor body so as to affix the elongate rod to the bone anchor;

35 inserting a removal tool into the pathway so as to 1) couple the removal tool to the tissue retractor at a first location so as to axially secure the removal tool to the tissue retractor at the first location and 2) decouple the tissue refractor from the bone anchor body at a second location spaced from the first location, wherein:

40 the removal tool includes at least one spring arm;

the tissue retractor defines at least one window; and

45 the step of inserting the removal tool into the pathway comprises causing the at least one spring arm to engage the at least one window to thereby couple the removal tool to the tissue retractor; and

moving the removal tool away from the bone anchor body so as to remove the tissue retractor coupled to the removal tool from the bone anchor body.

11. The method of claim 10, wherein the tissue retractor includes at least one resiliently movable arm that is movable between an engaged position and a flexed position, and wherein the step of coupling the tissue refractor to the bone anchor body comprises:

50 snapping the tissue retractor onto the bone anchor body such that the at least one resiliently movable arm moves to the engaged position and couples the tissue retractor to the body.

12. The method of claim 11, wherein a distal end of the removal tool includes an actuating arm and wherein the step of inserting the removal tool into the pathway comprises the step of:

55 causing the actuating arm of the removal tool to engage the at least one resiliently movable arm so as to move the at least one resiliently movable arm to the flexed position and decouple the tissue retractor from the bone anchor body.

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13. A method of attaching a locking cap to a bone anchor assembly that includes a bone anchor and an elongate rod, the method comprising the steps of:

positioning a cap guide adjacent to the bone anchor such that a cavity defined by the cap guide is aligned with a channel defined by a body of the bone anchor, the positioning step performed 1) after the bone anchor is attached to a vertebra and the elongate rod is positioned within the channel, and 2) while a locking cap is secured to the cap guide;

inserting a screwdriver into the cavity such that a distal end of the screwdriver is adjacent to the locking cap;

inserting an interlock end portion of a counter torque handle into the cavity so as to rotatably fix the counter torque handle to the cap guide while the screwdriver is inserted into the cavity; and

rotating the screwdriver so as to correspondingly rotate the locking cap with respect to the counter torque handle and thus also relative to the cap guide so as to attach the locking cap to the body of the bone anchor.

14. The method of claim 13, wherein the interlock end portion defines an instrument interface and an open ended slot, and wherein the step of rotatably fixing the counter torque handle comprises the steps of:

25 receiving the screwdriver within the open ended slot along a first direction such that the screwdriver is rotatable within the slot; and

30 translating the counter torque handle along the screwdriver along a second direction that is perpendicular to the first direction such that the instrument interface is received within the cavity of the cap guide.

15. The method of claim 14, wherein the cavity defines at least one spline and the instrument interface defines at least one spline, and wherein the translating step comprises:

35 mating the at least one spline of the instrument interface with the at least one spline of the cavity.

16. The method of claim 14, further comprising the step of attaching a tissue retractor to the bone anchor such that a pathway of the tissue retractor is aligned with the channel; wherein the step of positioning the cap guide comprises inserting the cap guide into the pathway such that at least two blocking tabs that extend from the distal end of the cap guide are received by at least two blocking ribs that extend from the tissue retractor and into the pathway.

17. The method of claim 16, further comprising the step of applying a torque to the locking cap with the screwdriver so as to cause the blocking tabs to apply a rotational force to the blocking ribs.

18. The method of claim 13, further comprising the steps of:

50 removing the cap guide and screwdriver from the pathway; inserting a removal tool into the pathway such that the removal tool couples to the tissue retractor and decouples the tissue refractor from the body of the bone anchor; and

removing the removal tool and coupled tissue retractor from the bone anchor assembly.

19. The method of claim 18, wherein the removal tool includes at least one spring arm and the tissue retractor defines at least one window and wherein the step of inserting the removal tool into the pathway comprises the step of:

causing the at least one spring arm to engage the at least one window to thereby couple the removal tool to the tissue retractor.

20. The method of claim 19, wherein the tissue retractor includes at least one resiliently movable arm that is movable between an engaged position and a flexed position, the at least

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one resiliently movable arm being in the engaged position when the tissue retractor is coupled to the bone anchor, and wherein the step of inserting the removal tool into the pathway comprises the step of:

causing an actuation arm at a distal end of the removal tool 5
to engage the at least one resiliently movable arm so as
to move the resiliently movable arm to the flexed position and decouple the tissue retractor from the bone anchor.

21. A method of attaching a locking cap to a bone anchor 10
assembly that includes a bone anchor and an elongate rod, the method comprising the steps of:

positioning a cap guide such that a cavity defined by the cap guide is aligned with a channel defined by a body of the bone anchor, the positioning step performed 1) after the 15
bone anchor is attached to a vertebra and the elongate rod is positioned within the channel, and 2) while a locking cap is secured to the cap guide;

inserting the cap guide into a pathway of a tissue retractor that is supported by the bone anchor such that the cavity 20
and pathway are aligned with each other;

during the inserting step, positioning at least two blocking tabs of the cap guide in rotational alignment with at least two blocking ribs of the tissue retractor such that the cap guide is rotatably fixable with respect to the tissue 25
retractor;

inserting a screwdriver into the cavity such that a distal end of the screwdriver is rotatably fixed to the locking cap;

rotating the screwdriver relative to the cap guide so as to correspondingly rotate the locking cap relative to the 30
body of the bone anchor, thereby coupling the locking cap to the body of the bone anchor;

during the rotating step, bringing the blocking tabs of the cap guide into contact with the blocking ribs of the tissue

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retractor so as to transmit rotational forces acting on the tissue retractor to the cap guide;

removing the cap guide and screwdriver from the pathway; inserting a removal tool into the pathway defined by the tissue retractor such that the removal tool couples to the tissue retractor and decouples the tissue retractor from the body of the bone anchor; and

removing the removal tool and tissue refractor from the bone anchor assembly.

22. The method of claim 21, further comprising the steps of:

rotatably fixing a counter torque handle to the cap guide while the screwdriver is inserted into the cavity such that an interlock end portion of the counter torque handle is received within the cavity of the cap guide.

23. The method of claim 21, prior to the rotating step further comprising the step of:

decoupling the locking cap from the distal end of the cap guide so as to nest the locking cap within the channel.

24. The method of claim 23, wherein the decoupling step comprises:

applying an axial force to the locking cap with the screwdriver such that the axial force decouples the locking cap from the distal end of the cap guide.

25. The method of claim 21, further comprising the steps of:

attaching the bone anchor to the vertebra;

attaching a second bone anchor to an adjacent vertebra; and

positioning the elongate rod the channel of the bone anchor and into a channel defined by a body of the second bone anchor.

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